The Journal of the
American Medical Association

VOL. XVIII. CHICAGO, JANUARY 16, 1892. No. 3.

ORIGINAL ARTICLES.

PRIVATE TREATMENT OF INSANITY.

Read in the Section of Medical Jurisprudence and Neurology, at the Forty-second Annual Meeting of the American Medical Association, held at Washington, D. C., May, 1891.

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Our conclusions are drawn from comparisons. Men rarely either express or entertain any idea that has not been acquired, or suggested, through comparison with more familiar ideas.

In the consideration of the subject of this essay, "the private treatment of insanity," we are naturally led—compelled, indeed—to compare this mode with public treatment of the disease, as uniformly practiced in public hospitals and asylums. As it is to be presumed, the tenor of my remarks will be favorable to the private treatment, as compared with public asylum treatment. And I therefore, at the onset, wish to make clearly known my high appreciation of the great good that has been accomplished by and through the means of our great, grand asylums; and that I would by no means be understood to hold that they are either useless or, as a rule, badly managed. On the contrary, I am glad to say, that nearly all our State asylums are well managed, and have accomplished an unmeasurable amount of good, alike to our insane, and their scarcely less afflicted friends. If any one doubts the value of the work that has been done by these asylums, let them for one moment contemplate the condition of society if, at the present time, they were wiped out of existence, and their legion of inmates let loose upon us. But, as new ages bring new inventions, so do new epochs, and greatly increased population, require augmented and improved means and facilities for their occupation, protection and care. A century ago, the condition of the country demanded public asylums; today, it demands more promising means of *curing* insanity, than are afforded by any public asylum within the scope of my knowledge. I shall but briefly refer to the relative treatment, and consequent probabilities of recovery, as practiced in public and private houses. First of all, I maintain that every public asylum in our land has such a number of patients (or inmates) that, being divided by the number of physicians employed, or engaged in attendance upon them, would give to each physician a larger number of patients than almost any practicing physician, in city or country. In other words, and briefly stated, no patient, in any one of our public asylums, is provided with the professional attendance that he ought to have, unless, indeed, it is in discrimination against some other patient in the same institution. Take, for instance, the institution with which I was for a long time associated; it is a fair sample of all the good asylums—indeed, half of the asylums in the United States were more or less copied from that one. There, we had about 400 patients, a separate building for each sex, and about 200 in each house, and each building supplied with two physicians; 100 patients to each physician, who, in addition to his professional care of his patients, had a large amount of executive and other work to do. Now I ask, how many physicians are there in the United States who, in private practice, see and prescribe for 100 patients daily? I venture to say there is not one, and yet this is expected of the physicians of our public asylums, daily, weekly, monthly, year in and year out. Such being the case, I ask in all candor, can it be expected that a patient, under such circumstances, has the same prospect, or opportunity of recovery, that he would have, if he had *all* the attendance his physician *could* give him? "But," the hospital physician will tell you, "this is all nonsense," that half his patients do not require medicine, or any treatment beyond feeding and restraint, and that ample care is given to all who need it.

Well, gentlemen, if there are any present who are, or ever have been, in charge of an asylum, let me ask if you ever told the guardians of that half of your patients that they did not need and did not get medical attendance? Was not "medical attendance" a prominent item in the bill rendered of that patient's indebtedness to the asylum? And, in all honesty, was not the asylum, in turn, indebted to him, or his estate, to the extent of the medical attendance which he did not get? I tell you, a large part of that half of your patients would soon be removed from your tender mercies, if the real facts were known to those who ought to know all about it. In a private hospital, the physician not only has the time to devote a sufficiency to each patient, but he is compelled to do so. Moreover, it is necessary for his own interest, and this selfsame self-interest has a great influence over all men, including physicians. In all public hospitals, there are some for whom very little, if indeed anything, can be done in the way of medical treatment. Others there are, concerning whom the question is doubtful, whether or not anything can be done. Let us contemplate the condition of this latter class of patients, and see where they would stand the best chance of recovery, *i. e.*, in a public or private hospital. In the former, he stands his chance with ninety-nine others, of seeing the physician at all. Next, it is conceded that fifty others have precedence of him, for the double reason that they imperatively demand attention, and that it is uncertain in his case, whether anything could be done anyway. The physician, wellnigh fagged out by the time he has prescribed for his fifty sick, is scarcely to be blamed if, from day to day, week to week, month to month, he puts off this unfortunate but unpromising, and perhaps not importunate, case. The consequence

is, he is permitted to become chronic, and adds one more to those who do not require medical attention. I tell you, I know how it is myself; and, whether or not anything *can* be done for, or towards the restoration of, these chronic cases, true it is, that nothing *is* being done. Why, at this very time, in my own State, the question is being strongly urged and argued, whether or not to build other, and separate asylums for the chronic, or incurable insane. It is well argued in favor of the proposition, that at present public asylums are more like places of detention, than curative institutions, and that under the present system, with the wards overcrowded with "incurables," neither the physician, nor the hospital itself, has the opportunity to do justice to those who are even regarded as curable. Could there be a stronger argument in favor of private treatment of insanity than this very admission, from the physicians and managers of public asylums? I think not. It is not within the province of this address to discuss the propriety of the proposed movement; but, so far as it would lessen the labor of the physician, or rather, remove from him duties foreign to his profession, and thus enable him to devote more time to his real and proper office of physician, and the consequent advantages to those who might be so fortunate as to be regarded as curable, why, I would be heartily in favor of the proposition. But what of the so-called incurable? I have very great objection to the whole suggestion, the moment I look at that side of the question.

First, I object to the word "incurable." Who has the right, and who ought to assume the responsibility, of so discriminating against a portion of our insane, as to brand them incurable? And when it comes down to a practical opinion, who is to say who are and who are not curable? If you or I had a friend in a State asylum, although he had been there a long time, would we be satisfied to see him removed from the very appearance of any effort to cure his disease, and restore him to the society of his friends, and placed as *incurable*, in a booth, as it were, with others, huddled together like a flock of sheep?

The present system of treating insanity cannot be accepted as universally satisfactory, and I need give but a single illustration to prove the fact. A bill is now before the Legislature of the State of Pennsylvania, which is said to have been drafted by ex-Judge F. Carroll Brewster, of Philadelphia, and which provides that *no one* shall hereafter be committed to an insane asylum in that State, until his case shall have been publicly investigated, and a jury of twelve men shall have decided that he is insane.

It is not required nor expected that this jury shall be composed of physicians, but ordinary, everyday jurymen. The bill assumes that sane men are sometimes committed to asylums, and its object is to prevent that abuse. Therefore the present system is not wholly satisfactory; and I could, if time permitted, give you other, and perhaps more weighty and better founded objections.

I cannot permit this opportunity to pass without expressing my disapproval of the proposed law. My first, and most positive objection to the measure, exists in the fact that insanity is a disease, and requires a physician, not only to treat, but to diagnose it; whereas, this proposed law assumes that physicians are either incompetent or improper persons to determine whether or not a patient is afflicted with the disease; that twelve ordinary, very likely uneducated men, are to be the absolute judges of the mental health of the patient. Could anything be more grossly preposterous? The delirium of typhoid, and other fevers, is practically temporary insanity, and who would dare to submit or trust to a jury of laymen the diagnosis of typhoid fever, or indeed any disease which requires the wisdom and experience of a physician to cure? Besides this, there are grave objections to the bill, *per se*. It has been tried in the State of Illinois, and I have had frequent opportunity to witness its impropriety; indeed, its oppression.

Many refined families object to giving any publicity to their misfortune of a visitation of insanity. This law debars their patient from proper treatment until the greatest publicity is given. So greatly have some familes in Illinois objected to the law, that several have carried their patients more than a thousand miles to avoid its provisions, and I have treated the patients, and personally heard the protestations of their friends. A still greater objection exists, and one that I think cannot be gainsaid, which is the loss of valuable time. In some forms of the disease, notably acute mania, promptness is of the greatest importance, and I have known of happy homes being kept in consternation for an unreasonable, unjust length of time, to comply with the provisions of this obnoxious law. I regret to differ even this much, with my good friend Judge Brewster, and gladly concur in his reasoning, "that even if a man were not entirely sane, yet if he were certainly harmless, he ought not to be imprisoned for life with melancholy surroundings, enough in a short time to drive a sane man crazy."

Insanity differs from ordinary diseases, in that restraint is a necessary part of treatment. I believe restraint is necessary in every case of insanity. Of course I do not mean to imply by the word restraint, that the patient is necessarily to be committed to an asylum, nor even deprived of his liberty. But, being deprived of such means of protection as mental integrity affords, he must be at least restrained from wandering into danger, and there is always danger when reason is dethroned. Now, the character and degree of restraint are subjects of the greatest importance. In public asylums, very little regard is paid to the *degree;* almost every patient is totally deprived of his liberty, and this I say is wrong. In such places, the character of the restraint extends from mere restriction to the premises, to solitary confinement, and sometimes to a single spot, by means of mechanical appliances. Now, I will go so far as to say that I believe there are cases, especially of violent mania, when such mechanical restraint is not only admissible, but affords the patient the best prospect of restoration.

I am aware that it is an unpopular admission to make, but we are now seeking for truth, rather than popularity, and I therefore add, that the public institutions which say they do not employ restraint, "the truth is not in them." They all, every one, employ restraint, and why do they deny it? I wish, however, in the most positive, plain, unmistakable manner to say, that no person enduring mechanical restraint should be left one moment alone, nor without the presence of a competent and *kind* attendant; and that the immediate relatives, or friends of the patient, should be honestly informed of the character and degree of the restraint to which he is subjected. Now,

in public asylums, such information is generally refused, whereas in a private place such friends may, if necessary, *demand* what is in most cases voluntarily extended to them, *i. e.*, personal information of the patient, and all his surroundings. In a public asylum, patients suffering the mildest form of insanity, and which perhaps, under judicious treatment, might be cured in a very short time, are brought into contact with the worst forms, features and consequences of the disease. Can there be a reasonable doubt that such surroundings would be detrimental to the partially insane? Again, the wealthy and refined are brought into contact with the poor, and sometimes coarse and vulgar. This disregard of social distinction I consider one of the greatest objections to public asylum treatment. Persons accustomed to gentility, who prefer refined society, and, through acquired means, have always indulged in a particular, even extravagant mode of living, should not be deprived of it merely because of a disease. That pioneer American alienist, our Dr. Benj. Rush, was of this very opinion, and unmistakably considered *private treatment* of insanity most desirable. In speaking of this subject of social distinction, and the importance of ceremonies which are due to their former rank and habits of living, and luxuries and observances they had been accustomed to in their own families, and for which they have formed habitual attachment, Dr. Rush, in his excellent "Inquiries and Observations on the Diseases of the Mind," says: "*The great advantage* which private madhouses have over public hospitals, is derived chiefly from their conforming to this principle in human nature, which the highest grade of madness is seldom able to eradicate." And again, strongly argumentative of the same theory, he said: "Recovered patients seldom forget three things: acts of cruelty, acts of indignity, and acts of kindness." Our public asylums are model institutions, and have restored thousands of insane to reason who, through poverty, could not otherwise have obtained treatment. But, if persons possessed of wealth can procure *better* facilities of recovery, why should it not be done? It *can* be, and I am fully persuaded that the time is rapidly approaching, when our medical colleges will each have a chair for the professor of insanity, and many physicians in private practice, devoted to that specialty.

It was an early custom in Java, to kill poor people who were afflicted with insanity, even of so mild a form that it was generally curable, if the patient could afford proper treatment. This was doubtless a cruel discrimination against the poor, but are we not to-day discriminating against the rich? There are already several excellent private hospitals for insane patients established in various parts of our country, and I am satisfied that their number will increase, as new physicians devote themselves to the specialty. This brings into prominence the importance of a suggestion I have repeatedly urged, namely: the proper selection, education and fitness of physicians who are hereafter to have charge of our insane.

My proposition, as repeatedly stated, is to employ, as attendants in asylums, young men and women who wish to study medicine, and who have to earn their way into the profession. It is of very great importance to select smart, intelligent people, for the immediate care of cultured persons who have become insane; and that they should be especially prepared for that responsibility, by education and careful practical training.

Asylum attendants are too often selected for their strength of muscle, and low wages; and this is why we so often hear of their patients being brutally abused. Brute force should never be permitted, and when places in our asylums now occupied by that class of attendants, shall be supplied by medical students, of whom there is an adequate number desiring any occupation by which they can earn their livelihood during pupilage, I am sure, from practical experience and observation, that troublesome patients will not only be more kindly nursed, but that, under such treatment, a larger number will recover.

The second, but no less important, advantage to be derived from the proposition is, that when such students graduate, they will have acquired several years' practical experience in the treatment of the insane, and it cannot be doubted that many of them will adopt that branch of the profession as their specialty, and whether in public or private asylums, or in private practice, bring all their former experience into practical use; curing a larger number of patients than has yet been done, and perhaps eventually restoring many of that unfortunate class, now termed *incurable*.

Wissinoming, Philadelphia, May 2, 1891.

THE HUMAN NOSE NOT IN THE CENTRE OF THE FACE. ITS IMPORTANCE IN THE ADJUSTMENT OF SPECTACLES.

BY A. C. SIMONTON, M.D.,
OF SAN JOSE, CAL.

The fact that the human nose, as a rule, is not situated in the centre of the face, I have never seen stated in any medical journal, or any text-book on ophthalmology that has come under my notice. The importance of this fact to the oculist can scarcely be overestimated, when considered in connection with the adjustment of spectacles for correcting errors of refraction. This fact may have been stated before, but if so, it is strange that it has not been incorporated into every text-book on ophthalmology which deals with the errors of refraction. Every one of these works insists strenuously on the necessity of adjusting glasses accurately to the face, so that the optical centre of lenses shall stand exactly in front of the centre of the pupils, unless for certain reasons the lenses are decentred to get a prismatic effect.

In measuring the face for the adjustment of glasses, oculists are in the habit of measuring from centre to centre of pupils, without regard to the position the nose occupies between the two eyes. Frames are ordered to correspond with the measurement, being exactly the same distance from centre of nose piece to centre of eye wire on either side. Glasses are ground with optical centres in centre of eye wire. Now, instead of having our glasses properly centred before the eyes, as is insisted upon by all authorities, and as every oculist knows the importance of, in a large majority of cases, our lenses are placed in such position as to give a prismatic effect not desired or intended. Is it not possible that herein lies one of the reasons why patients occasionally reject glasses that have been found by proper tests to be their optical correction?

The difference between the two sides from centre

of nose to centres of pupil is, as a rule, from $\frac{1}{16}$ to $\frac{1}{8}$ of an inch, seldom is the difference beyond $\frac{1}{8}$ inch. But if the difference is $\frac{1}{4}$, and lenses are mounted in the ordinary way, we have a decentering of both lenses to the right or left, as the case may be, of $\frac{1}{16}$ inch. If the greater distance from centre of nose to centre of pupil is on the left side, then we have, if our lenses are convex, a prism also for left eye, with base in, and for right eye a prism with base out. If they are concave, the reverse would be true. Persons familiar with this subject know how important this would be in lenses of medium to high power.

This brings in a new element not heretofore considered in the grinding and mounting of spectacle lenses. In presence of the facts stated, we are under obligations to take cognizance of the same, and in every case satisfy ourselves whether the centre of the nose is in the exact centre between the two pupils. It becomes necessary to make the centre of the nose the starting point for measurement. I have constructed a simple little instrument which answers admirably for measuring either way from the centre, as follows: Take a piece of wood 6 inches long, 1 inch wide, $\frac{1}{4}$ inch thick, draw a straight mark across its exact centre, and then one on either side just 1 inch from this, with the blade of a knife. Outside of the two outer lines mark accurately $\frac{1}{16}$ inch marks until you have reached a $\frac{1}{2}$ inch beyond, making marks near the edge. These marks may all be colored with ink. Now cut out a concave notch in the centre of the marked edge, about $\frac{5}{8}$ inch wide and $\frac{1}{4}$ inch deep. This notch will fit down over the nose, when you must see that the centre line of your measure is exactly over centre line of nose. Now read off to right and left 1 inch and so many sixteenths. Of course any one's ingenuity will suggest how to neatly make this measure. You may construct one much easier by taking a common thin-edged, wooden measuring rule, and make the notch in it at any inch mark; you have your inches and sixteenths on either side already provided. Our instrument makers, no doubt, could construct something very neat for these measurements, with a handle just above the centre, a concave portion just beneath this to rest on nose, and arms extending out to right and left, with proper intervals marked thereon. This might also have little slides with points to stop in front of pupils.

But the measures being taken, what about the mounting of glasses? Surely they must be so set in frames that the optical centre of lens comes before the centre of pupil, no matter where the centre of eye wire is. The frames cannot be constructed longer on one side than the other, else they would not balance, but the lenses must be decentred in grinding to correspond with measurements. This will necessitate a new form of prescription blank, first giving the total measurement between pupils, and then the measurement of each side.

I have examined a large number of faces since the fact herein mentioned came to my knowledge, some months since, and I find it quite the exception for the nose to be centrally situated. I made the discovery on my own face, in which case the right pupil is $1\frac{1}{8}$ inches from centre of nose, and left $1\frac{1}{4}$ inches.

THE Woman's Medical College of Minneapolis has been incorporated according to law.

MODERN MEDICAMENT.

BY C. B. MEDING, M.D.,
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Of the physician's duty toward his patient much has been set forth by the press, medical, religious, and secular. It remains for our body to present and enlarge upon as well as to impress one another with the importance of our duty toward ourselves. Though often lost sight of, it is still of first magnitude, morally, professionally, and financially. However strongly it may be held that professional life has in consciousness its own reward, however often it may be reiterated that worldliness is no part of our creed, the truth remains that, in common with the rest of humanity, we must live and must fight for life. We have enemies, we have opposition and competition, antagonistic factors that will of necessity be victors or vanquished.

Not a few of us here present have found that the voyage is not over an altogether smooth sea, is not free from storm and hurricane, not safe from shoal and rocky coast line, and while we pilot fellow craft through the billows of accident, while we gear the engines of stranger ships, if we would be thorough seamen we must steer our own bark aright, weathering successfully the tempests we are sure to meet.

The old has no rights over the new, whether in medicine, theology, philosophy, or astronomy; its principles must change with the times, its tenets must bear reform. To the survival of the fittest there is no exception, and while we accept for diagnostic purposes new etiology, new methods of examination and deduction, we must perforce take hold on new treatment.

I am afraid that many who are and ought to be opponents of homeopathy know little of the real therapeutics, much less of the principles of that school. I am afraid that outside of "similia similibus curantur" and "high dilution" little is known or cared. But a direct and successful opposition must be based on knowledge. If the system of medicine practiced by us is right, if it is worth study, attention, and continuation, it is also worthy of protection. If the opposers of it claim fallacies as against it, we as men should be prepared to maintain our position by a full refutation based on intelligible facts, and I am one steadfast believer and practitioner of the old school who has had the truth forced upon him that homeopathy is, under existing circumstances, his greatest enemy, that it has done and is doing more harm to all regular practitioners than any form of quackery; that it has made many semi-converts and at the same time has fostered ignorance and misapprehension; all this not because of superior efficiency from strength of basis or soundness of principle, but through pleasant dosage and a common sense plan of cheap and ready medication.

The age that cries for rapid transit, electric conveniences, automatic novelties, in a word, for everything that may lessen the friction of life; the age that demands comfort, ease, and luxury, in every by-path of its daily walk, will not accept vile concoctions even at the hand of learned men, nor will it long consider learned those who continue such medication, and the best purpose homeopathy can ever serve will be the teaching the abandonment of filthy compounds.

There is no reason why we should persist in prescribing nauseating drugs. The moral effect of such medicine may be useful in hospitals, purging them of

simulating patients; the so-called "bum mixture" has its place, but alas it is most often prescribed in private practice to delicate patients. Let me recite a few facts and see if we can find causes for them.

It is a common occurrence to find parents choosing homeopathic treatment for their children, they remaining alopathic.

It is commonly said by intelligent persons: "Oh yes, in severe cases I prefer the old school, but for simple ailments homeopathy will do."

It is not uncommon to find a homeopathic medicine book in the homes of old school people.

Few physicians have escaped the pleasant scene of a couple of half filled tumblers with the ever present saucer and spoon, in the nurseries of their patients.

We cannot, if reasonable men, ignore the homeopath, nor browbeat the laity with any satisfaction. We cannot sanely call all homeopaths fools, and decisions arrived at by the popular mind are the indicies of progress, and popular logic has its place. This being the case one cannot ask a people to more readily believe in the necessity of assofœdita and senna than that the thirty-third dilution of a single drop is stronger than the drop itself. Both are preposterous, but of two evils common sense chooses the pleasantest.

I do not consider it a difficult task to prove the falseness of homeopathy considered as an all providing and sufficient system. Any man can prove empiricy to be the only sure basis, but to prove worthlessness in anything but sin is impossible. Outside the more or less well defined circle of physiological effect on the average normal subject, we find individual idiocyncrasy a powerfully modifying factor. But the dose admits of common sense. We cannot deny two things; first, that with liquids the old school prescribes *large* vials and *spoon* doses while the homeopath gives *small* bottles and *drop* doses; in solids we lean toward *few* pills or capsules regardless of *size*. The homeopath gives *small* pills regardless of *number*. I ask you, both being possible, which is the most reasonable?

Two further factors worthy of consideration are the *patent medicine* and the *drug store*.

As regards the first I believe its success is due not to the gullibility of the public, for many purchasers are intelligent reasoners, but to three inherent and ever present merits, *cheapness*, *pleasantness* and *safety*, exactly the merits of homeopathy, precisely the merits, gentlemen, that recommend any purchasable artible. *Cheap* because they diagnose, explain, and treat for the same money; *pleasant*. Take any one of the successful remedies of the day and tell me, despite your opposition, are they not elegantly prepared? do they ever sour, mould, or precipitate? Are they ever unsightly? Is there any illegible writing to be read? Are they ever nauseating? Are they not always one bottle exactly like another of its kind? *Safe*, for obvious reasons. Is not the reverse often true of our prescriptions?

The *drug store* may be justly likened to a traitor in friendly garb. It is not the counter prescribing, nor yet the information culled from presciptions that effects the question, but the prices charged for drugs. Of this the most casual observers need neither explanation nor example other than their own experience. With some there may be a question as to where to draw the line of personal affairs. For my part I must admit that the vast majority of people belong to the great middle class, to whom success means simply a balanced ledger at each year's end, and to whom extortion is robbery. Every man has the right to do as he will with his own. If I am not satisfied, you say, I may go elsewhere. True, but in the time of necessity I must pay, for I am compelled to have. A price based upon the sum of cost and profit is reasonable, but there is no honor nor fairness in the price based on man's necessity.

Many reputable physicians have taken to carrying with them a supply of simple drugs, believing that they are entitled to a share of the patient's money. It requires no deep reasoning to see that a man in humble circumstances cannot pay equally doctor and druggist, and that if the doctor must give credit while the druggist need not, the former is the loser.

More than this, some physicians are to-day carrying a small stock of common medicines for office practice. This is a good thing, it will have a twofold effect. It will cause the city physician of the old school to become acquainted with the medicines he prescribes, will cause him to consider palatability, and patronize all efforts to afford a happier dosage; it will also compel the stores to sell at more reasonable prices. It is our duty to oppose all, who antagonize the best interests of the highest profession and prosper homeopathy, charlatanism, and patent medicine.

The day is happily not far distant when the uneducated will be cut off from medical study; when State examinations will make low grade colleges impossibilities, but at present there are many good reasons why we confess so many sad writers and poor students. Incompatibility is now taught to prevent poisonous or explosive compounds and for nothing more. It has been said that city physicians have least faith in the materia medica, country physicians most; true it is that the former never compound, seldom see and never taste their medicines, hence their fearful mixtures.

Now a few points along which to draw the lines of opposition. It is time for us to,

1. Combat the growing impression that *old school* means dosing.

2. Prove that *alopathy* does not mean extravagant drug bills.

3. Prove that we, too, can treat the emergency and are not *altogether* dependent on the drug store.

These three now truthful ideas may be banished successfully by following the physiology, chemistry, therapeutics, and common sense of the day. Let us,

1. Reduce four and six, and eight ounce vials to one, two and three ounce; and the dose from drachms to minums.

2. Reduce the number of prescriptions, seeking simpler medication and less complication.

3. Use consentrated tinctures and extracts, compressed solids, and active principles.

4. Abolish decoctions, infusions, and crude drugs; cease ordering ounces of vehical to carry grains of medicament.

5. *Carry carefully selected drugs*. Dispense such medicines as may be conveniently handled, raising our profession to its old time usefulness. Such a course will,

1. *Reduce the price*. A druggist cannot charge the same for a two ounce as for a four ounce vial, even though the difference be only *boiled* water. It will

2. *Abolish* that large *class* of preparations of which

our text-books say, "*used mostly as vehicals.*" It will,

3. *Prove us consistent*, for it is no more ridiculous and blameworthy to attend a confinement without ergot, instruments, and antiseptics, than to enter the abode of sudden sickness at midnight armed with simply paper and pencil.

There is an opinion abroad that the doctor has nothing to do with cost, but my impression is that doctor from doceo means to teach, and the good teacher is interested in all that affects his pupil. He who is not a teacher is not a doctor, but a leech; of course it is for every man to choose his own professional title.

A druggist is no relation to a physician and he should be none. The percentage system is criminal extortion, and that man illy serves his patient who lays up treasures in a druggist's till. I believe that if every physician would buy his drugs, his own prescription blanks, segars, postage stamps, etc., it would be better for all hands.

It cannot be brought against such rulings that heroic treatment necessitates dosage, for nastiness and quantity are not synonymous with strength.

Again, why should we not seek the proper compounding of preparations? Why should pills be made in sixteenth century sizes and modes, if they are to be sold at nineteenth century prices? Why should not fresh parvules and pills and tablets be made by men who style themselves dispensing chemists, apothecaries and pharmacists?

Lastly, why cannot we turn against medicines famous most for their filthiness?

You ask where this line is to be drawn. Will not palatability lead to the elixer, would that be advisable? Such is the argument and objection of the extremist. It is not necessary to have the child cry for medicine. I do not desire adults to prefer drugs to food. Very far from my creed is it to claim that medicament must be nice or useless. Many times in the practice of every man will come the cases where taste and cost sink in the imminence of death, but in over two-thirds of our cases, petty ills, trifling disorders, and simple ailments comprise the trouble, and here we can show that the grand old school has not only age but also modern weapons for the warfare with disease.

The country physician laughs at the city man's medicine, yet he has learned better only by experience.

Is it true that the homeopath has better results with children than we do? Well, if it is true, the reason is not in any superior system, but in drops instead of drachms; in pellets instead of marbles.

You cannot read how to improve; there are no books, no colleges. Edinburgh, Glasgow, London, Heidleburg, and Vienna, all are fighting tooth and nail for the black draught and blue bolus. Improvement, progress, civilization, however, demand responsive souls. You cannot bribe the great time, it will onward and in its train humanity rises to higher levels.

The searing iron stopped many a hæmorrhage in the past, why not continue its use? Microbes were never molested until lately, why bother them now? Thousands of persons were operated without anæsthetics and survived, why so tender now?

Because the age demands, invention supplies, and discovery brings forth. We are working, studying, pressing forward and onward toward a brighter, higher end. Then can you lag behind? Dare you loiter, tracing out old footsteps time has well nigh obliterated? Dare you stand copying masters, progress calls children? Is it not your duty to steer this light-ship carefully, scientifically, reasonably, always mindful of the good, ever willing to discard the bad? That they who navigate the eternally rolling sea may, seeing its brilliance, guard their craft accordingly.

INTUBATION IN DIPHTHERIA.

Read before The Mitchell, Ind., District Medical Society, Dec., 17, 1891.

BY P. RICHARD TAYLOR, M.D.

I will make a strictly clinical report of four cases of intubation, selected from a number during the recent endemic of diphtheria in Louisville, two of which were fatal, and two successful.

Case 1.—Oct. 29th; I was called by Dr. Ernest Yeager to intubate the larynx of Robt. W., æt. 7 years and 5 months. On examination I found diphtheritic patches on the tonsils and in the pharynx. In the larynx the mucous membrane was swollen and tumefied, but there was no false membrane. Respiration, 36 per minute; pulse 150 and thready; temperature 102½. He was in a semi-comatose condition and very much cyanosed. The intercostal spaces were depressed and did not rise with inspiration. The dyspnœa was distressing. A tube the size required for an eight year old child, was introduced into the trachea, which relieved the dyspnœa immediately. At the end of an hour, respiration was 22; pulse, 140. Quinine by inunction and iron internally were prescribed. Milk, six parts, whisky, one part, to be given alternately with beef extracts, were ordered for nourishment. A spray of peroxide of hydrogen was used every hour. The following morning, the temperature was 99½; pulse, 120. I saw the child again on the sixth day, found the temperature normal; pulse 100. The tube was removed on the seventh day, the child making an uninterrupted recovery.

Case 2.—Nov. 2nd., I was called by Dr. Robert G. Fallis to intubate the larynx of Rose H., æt. 2 years and 8 months. Upon examination, I found diphtheritic membrane in the nares and pharynx, on the tonsils and tongue and in the larynx. The child had been sick but forty-eight hours; the temperature was 102; the pulse, 150; the dyspnœa excessive and progressing. A tube the size required for a child three years old was introduced into the larynx, relieving the dyspnœa immediately, and in ten minutes the child was asleep. Quinine by inunction, iron internally, were prescribed. A spray of sulphurous acid and water, equal parts, was ordered. Milk and whisky, alternately with beef extracts, were given as nourishment. On the morning of the second day, found the temperature 100; pulse, 130. On the morning of the third day, temperature 101; pulse 140; face flushed; membrane yellow and breaking down. A spray of peroxide of hydrogen was ordered to be used every hour. On the morning of the fourth day, temperature 104; pulse 150 and thready. On the morning of the fifth day, the temperature was 105½; features pinched; respiration 36, very restless. These symptoms continued until the child died in the afternoon from septic poison.

Case 3.—Nov. 5th, I was called by Dr. Ernest Yeager to intubate the larynx of Clarence M., æt. 2 years and 8 months. Considerable delay was occasioned in reaching the child which I found uncon-

scious; extremities cold; sphincters relaxed; wrists pulseless; and pronounced apnœa. A tube the size required for a child four years old, was introduced into the larynx without delay and artificial respiration continued for a few minutes until respiration was restored. At the end of the hour, the patient was conscious; respiration 22 per minute: temperature 101; pulse 140. Milk and whisky were given as nourishment, and quinine by inunction was ordered. A spray of peroxide of hydrogen was used every hour. At 8 P.M., two hours later, I received a message to the effect that the child had dislodged the tube while coughing. Upon examination, I found a large piece of membrane tightly plugged into the lower end of the tube, which prevented the escape of the air from the lungs, and the child's effort to remove the obstruction by violent expiration had forced out the tube. A tube the next larger size was substituted, and on the sixth day it was removed, the child making an uninterrupted recovery.

Case 4.—On the morning of Nov. 5th, I was called by Dr. G. Fallis to intubate the larynx of Julia S., æt. 20 months, a case of two day's standing. The dyspnœa was present on the first day and had gradually increased. I found membrane on the tonsils and epiglottis and in the larynx. A tube the size required for a child two years old was introduced into the larynx, with prompt relief of the dyspnœa. The temperature was 101½; pulse 148. Quinine by inunction prescribed. Whisky and milk given as nourishment, and a spray of peroxide of hydrogen was directed to be used every hour. The following morning, the temperature was 99½; pulse, 120. Digitalis was prescribed on the third day, temperature was normal, pulse 115. Patient improved steadily, and tube was removed on the fifth day, and the breathing was almost normal; pulse 110. Two days later, I called with the doctor and found the dyspnœa sufficient to warrant replacement of the tube. I found no membrane, but the lining of the larynx was tumefied; pulse 140 and thready; temperature normal. Three days later I visited the child, found it playing with its dolls; temperature normal; pulse 115, thready. The child kept its mouth tightly closed and its nostrils widely dilated. Its appetite was good. I, again, removed the tube; respiration was normal, but the child continued to keep its mouth tightly closed and its head bent down. Examination showed the palatine muscles were paralyzed; the soft palate flapped back and forth as the air passed to and from the lungs; the vocal cords were stretched wide apart; the apex of the epiglottis was curled upon itself. Three hours later there was a recurrence of the dyspnœa; fearing it might grow serious, I replaced the tube. Late in the afternoon of the same day, I received a message that the child had died suddenly while playing on the floor. Examination showed the tube was in its proper place, the child evidently dying from heart-clot.

Intubation, in diphtheria, is indicated as soon as dyspnœa becomes progressive, and is due to laryngeal obstruction resulting either from false membrane, or tumefying of the mucous membrane and surrounding tissues, under which conditions the introduction of the tube gives immediate relief.

The size of the tube is governed by the child's age, according O'Dwyer's system of measurement, except in such cases where the tube has been dislodged by coughing, when I invariably substitute the next size larger, and this latter, my experience has taught me, is absolutely essential.

The nourishment must be liquid, or else in the form of ices, and must be administered by the spoonful, the patient either sitting in the upright position, or lying on the side, and taking the entire contents of the spoon at one swallow to prevent the passage of the liquid into the tube.

The removal of the tube between the fifth and the ninth day, ordinarily, is safe, but in some cases, I have left in position as long as twelve days. Its removal leaves the vocal cords stretched wide apart, the epiglottis standing almost straight and stiffened from being held several days in one position, and also leaves it unable to perform its normal function, rendering it necessary, for one or two days longer, to give liquid food by a spoon.

In two cases cited above death resulted from septic poisoning and heart-clot, and, frequently, exhaustion is the fatal cause. The specialist renders breathing possible, yet he, with all his apparatus, and the general practitioner, with all his medicine, can give but a grave prognosis in diphtheria.

LAPAROTOMIES PERFORMED DURING THE PAST YEAR.

BY THOMAS OPIE, M.D.,
OF BALTIMORE, MD.

Mr. President and Members of the Southern Surgical and Gynecological Association:

It is with no little diffidence and apprehension that I offer this Society a paper which is the beaten track and the hackneyed theme of a narration of cases, especially since it has been made up little by little as the fragments could be wrested from the busy activities of the practical doctor.

I do not come before you with the promise to present new, and therefore interesting facts; all of us might admit the paucity of facts, even in the great province of medicine, yet all are earnestly looking and longing for them. Every statement, proposition or theory in any department of medicine before it can be reckoned among settled facts, must be submitted to a calm judicial consideration, publicly and openly, before the bar of the medical profession.

In new fields the caution and deliberation of the profession is especially commendable. The experience of many observers is desired; full and free discussion is sought; extensive statistics are essential. In submitting this statement of a year's work in Abdominal Surgery, though it be small as compared with that of many operators, it is to be hoped that it will elicit a full and frank interchange of experience and thereby help, in some measure, progress in this department of Gynecological Surgery.

In doing so, I do not hesitate to say, that every narrator of his personal experience should, when before the tribunal of the Profession, feel that the withholding of a single error of omission or commission, vitiates his confession. We want the truth, but more, we earnestly desire the whole truth.

Statistics framed in this spirit would be invaluable to the profession and therefore, to the human family. In other words, "every man should be his own critic." The accompanying tabulated statement embraces thirty-two abdominal sections made in the twelve months, beginning November 1, 1890, and ending October 31st, 1891.

This list does not include the whole number of laparotomies performed at the Baltimore City Hospital during the time stated, since this institution opens its doors to all operators of good professional standing, who may see fit to attend and operate on such cases within its walls.

The writer had the misfortune to receive an attack of septic empoisonment on December 10, 1889, from the prick of a pedicle needle, while performing a laparotomy on a case of septic peritonitis. This report therefore, represents his first year's work, immediately following that interruption, which lasted over a year.

It has been said in connection with this important and relatively new work, that there is "too much surgery."

In answer to this charge, I would say that this question can best be decided by surgeons.

"Everything is by calm behest,
Besigned to him who understands it best,
But every wordy, theoretic leech,
Can teach the teacher how he ought to teach."

It is a sad state of things if we can say of any individual surgeon that he is not wiser at the end than at the beginning of his year's work. He can, however, no more than the physician, claim immunity from mistakes. If he be wise or skilful, he will not be chargeable with repetitions of the same mistakes; thus he, as well as his future patients, will profit by his failures. Moreover, there is inevitably an error in judging the work in this or any other branch of medicine, by the results of individual operators. The whole of a thing can never be accurately determined by any one of its parts.

The statistics in this new field are as yet comparatively small, and the facts are few. It is quite well established that the happenings incident to surgery will bear a very close relationship to each other in every one hundred cases. It is equally true that knowledge, calmness, deliberation, cleanliness and promptness in coping with emergencies, constitute the differences between surgeons. A succinct definition for science is, methodized knowledge, but something must be added to cover the work of the surgeon, viz.: common sense and sound judgment. It is also true that with a skilful surgeon, each 100 cases in his own experience, should be a success beyond its predecessor.

Would it not subserve a good purpose to adopt some uniformity in our mode of collecting statistics? It might be an improvement if all members of this Society would alike, report their work in this department fully from one meeting to another, or at least upon some uniform plan. As it is, the statements are fragmentary, and therefore, not so valuable, since successful cases are given prominence and failures are apt to be overlooked. It is agreeable to recount our successful ones; it is a very severe test to confess our losses.

What there has been of error or detraction in my work, I will, as frankly and as fully as I know how to do, place it before you conspicuously in the early part of this statement; nor will ask you to "hide the faults (you) I see."

UNSELECTED CASES.

The operations were performed consecutively as set forth in the accompanying table; they were:

Ovarian Tumors	6
Chronic Ovaritis	7
Fibroid Tumors	4
Pyo-salpynx	5
Retroflexions with adhesions and dysmenorrhœa	3
Exploratory Incisions	3
Extra Uterine Pregnancy	1
Abscess of Ovary	1
Cyst of Broad Ligament	1
Cystic Degeneration of Ovary	1
Total	32

Nine of these patients came to me through the dispensary connected with the College and were operated on in the amphitheatre before the whole class at the College of Physicians and Surgeons. The remainder, twenty three, were operated on privately. Twenty seven were white and five were colored.

DEATHS.

The deaths were as follows:

Oöphorectomy for Pyo-salpinx	1
Shock from Ovariotomy	1
Oöphorectomy for Acute Mania	1
Abdominal Hysterectomy for Fibro-Cystic Tumor	1
Total	4

No attempt will be made to describe fully each individual case, but the classification will admit of a separate discussion of the various classes of disease or operations and enable the writer to select and lay before the Association what seems of special interest.

In such a report as this the deaths are commonly regarded as a stigma, nevertheless they are usually instructive. I must give a full account of my stewardship, and consequently trespass upon your time with the details of each one of them.

Case 7.—Colored servant, single, had received dispensary treatment for several months for gonorrhœa. The diagnosis was made out correctly, as the sequel proved, as gonorrhœal pyo-salpinx. The urgent necessity for surgical interference was impressed upon the patient but the operation was long deferred. On the 5th of February, 1891, a laparotomy was performed. Both ovaries and both tubes were matted together and adherent to the intestines in the posterior cul-de-sac. They were with difficulty removed. The left tube burst in detaching it and its virulent contents were discharged into the peritoneal cavity. The pus was easily squeezed out of both tubes, after removal. The abdomen was flushed out. Alarming hæmorrhage ensued from the denuded surfaces of the cul-de-sac which was arrested by packing it firmly with iodoform gauze. This was removed in six hours. Her temperature rose to 101 degrees during the night and reached 103 degrees the next day; pulse 130. She died on the third day of septic peritonitis.

Post-mortem: Flakey lymph and pus over intestines. No fluid in abdomen. Ligatures had held securely.

Case 10.—White, age 50, married; visited me at the hospital about February, 1891, received an opinion that she had an ovarian tumor which was fully developed, and should be removed at once. This advice was disregarded. She returned home and remained there until about six or seven weeks later, when a letter from her physician impelled her to come on for the much needed surgical treatment. She was admitted on the 16th of March, and operated on the 19th. Her condition was bad. Her temperature was 100 degrees and pulse rapid. Her abdomen was very sore under palpation. The colloid contents and the solid elements of the tumor weighed over twenty pounds. The whole abdominal wall seemed ablaze with inflam-

mation; the intestines were largely adherent to the tumor and matted together. The contents of tumor would not run, but had to be scraped out piecemeal by the hand. She was profoundly shocked; hypoderms of whisky were given freely; milk, beef tea and whisky were administered per rectum; though retained, they were of no avail. Death ensued at 3 A.M., I think from surgical and chloroform shock.

Post-mortem by Prof. Kierle. No blood in abdomen whatever; abdominal cavity perfectly dry. Ligatures tightly adherent to parts. Organs healthy. Died of shock.

Case 18.—White, aged 18, single, family history good. Had had periodical attacks of mania. The first attack came on simultaneously with her menstrual flow at fifteen years of age. Her menstruation was always accompanied by severe pain. Six months ago she had so severe an attack of mania that she was sent to an insane asylum. On the third day after the operation, mania set in; she could not be kept in bed. It was impossible to keep her bandage on. She grew more and more violent and died January, 23, 1891, thirteen days after the operation.

Post-mortem by Prof. Kierle; complete post-mortem not allowed. Kidneys markedly congested. No fluid in abdomen. Lungs congested. Brain not examined; probable cause of death here.

Case 32.—W. M., white, married when 21 years of age, sixteen years ago; had three children and one miscarriage.

Five years ago noticed a tumor in her abdomen, which gradually grew larger and was said to be an ovarian cystoma. She suffered from frequent hæmorrhages. They were profuse in character, and at irregular intervals. On examination, a tumor as large as a man's head was realized in the abdomen. The uterine probe ran up into it three-fourths of its length. An abdominal incision was made about eight inches long; the tumor was lifted out of the abdomen and secured by Baker-Brown's clamp. The bleeding was readily controlled, and the peritoneal cavity flushed. The abdominal wall was closed with silkworm gut and the stump secured in the lower angle of the wound. Though severely shocked, she rallied well. The mass comprising the fibroid, womb, ovaries and tubes, weighed ten pounds.

The patient did well for three or four days, but after this her pulse and temperature began to rise, and she died on the seventh day of septic peritonitis.

Post-mortem by Prof. N. G. Kierle; wound had entirely healed up; the clamp was tightly holding the stump. Abdomen contained two ounces of bloody fluid. The intestines were adherent and covered with inflammatory lymph. Kidney soft and fatty; liver, fatty. Death from septic peritonitis.

EXPLORATORY LAPAROTOMY.

Case 4.—Age 46; operated on January 5, 1891. The exploration revealed malignant degeneration of the left ovary, with cancerous cysts studding the peritoneum and intestines. A large amount of abdominal fluid was removed. The cavity was thoroughly flushed and the walls closed. Patient returned home in three weeks greatly improved. It must needs have been temporary.

Case 22.—Age 25, married, sterile. Operated August 26, 1891. A large malignant growth was found in the left side involving the corresponding ovary and the liver. Patient had icterus at the time of operation. Stitches removed on the eighth day. She improved rapidly and returned to her home in good spirits.

Case 26.—M. O., age 33, widow; had two children and one miscarriage during wedlock. Operation, Sept. 26, 1891. Performed criminal abortion with a tortoise shell bonnet pin. On admission a digital examination was made. The pelvis was blocked with exudates. In the centre of the posterior cul-de-sac was a boggy point, the field all around solid to the touch. Percussion and palpation indicated the extension of the inflammation and effusion high up on the left side of the abdomen. The temperature in the mornings was about 101 degrees; in the evenings 102½ to 103 degrees.

An exploratory incision was decided upon, and made in the median line. It was impossible to explore the pelvis; the strong resistent adhesions and exudation was an effectual stay law. A large amount of bloody serum was flushed out. The temperature, at the time of operation 102°, began to decline at once; the effusion was gradually absorbed; at the end of three weeks there was no sign of the pelvic trouble. Drainage was not used in any one of the three exploratory laparotomies.

The number of these cases is too small to prove anything, but they are suggestive and add to already strong testimony which is recorded, that a laparotomy done in a thoroughly aseptic manner is a warrantable resort, when the indications are threatening and the diagnosis doubtful.

OVARIAN TUMORS.

The six cases of ovariotomy made good recoveries with the exception of No. 10, in which there was realized extensive peritonitis on opening the abdomen. This case is reported among the deaths.

Case 2.—White, single, aged 38, was an interesting case, since in addition to the cystoma of the right ovary, which contained two and a half gallons of fluid, there was on the left side a dermoid cyst, the size of a child's head. The contents consisted of bone, hair, etc. The pedicle of this tumor was four inches wide, hence there was some difficulty in constricting it efficiently even in sections. This patient, strange to say, menstruated regularly up to August 25, last, within three months of the time of operation. She suffered from attacks of mental aberration during a year prior to the operation. Excellent recovery ensued both mentally and physically, which has been maintained without interruption from the time of the operation up to this date.

Case 21.—White, single, aged 16. Her abdomen approximated the size of a women at full term, before the operation. She and her friends noticed the enlargement of her abdomen for the first time four years ago, when she was twelve years of age. It is fair to conjecture that it had filled the pelvis, and like pregnant uterus had developed into the abdominal cavity at that time. If there is a parallel between the nutritive growths in these two conditions, this tumor must have started at a very early age, possibly when she was eight or ten years old. Her first menstruation was in January last, and it recurred irregularly afterwards. She bore the operation and the subsequent treatment with great fortitude and made an excellent recovery.

The other four cases of ovarian tumor presented nothing of special interest, save their complete and permanent recovery.

CHRONIC OVARITIS.

In this class there were six. Among them was Case 17; single, age 20. She began to menstruate at fifteen. Her first epileptiform spasm began coincidently with this event. From that time up to the time of the operation, she had these attacks both during the interim and at the time of the menses. The attacks were more severe just preceding the establishment of the flow. They were attended by convulsive movements of a pronounced character, followed by a period of stupor and sleep, lasting fifteen or twenty minutes. At other times they were caused by over-tax, by mental worry or excitement. The intermenstrual spasms were attended by slight twitchings and a short sleep. Her friends, prior to seeking relief by oöphorectomy, had spent quite a fortune in their efforts to cure her, having had her under treatment of some of the most eminent neurologists in New York. Electricity, massage, drugs, all in turn proved unavailing. No difficulties arose in the operation. A few days after the operation she had several spasms, but no harm ensued from them. Convalescence was uninterrupted and rapid. She spent several weeks at the sea-shore and paid me a visit on her return home. The young lady had gained notably in weight and strength but the intermenstrual form of the attacks still recurred. At this writing I am unable to state her condition.

Case 18.—White, single, 18 years of age, was an interesting case of this class, who had an attack of acute mania at the first menstrual flow. Six months ago she had a recurrence of insanity, and was sent to an insane asylum. Oöphorectomy was followed by acute mania. She was uncontrollable. Death ensued from sepsis. The case has already been reported in this paper under the caption of the deaths.

Case 12.—White, single, age 21. Had always been sick since childhood; had been for years subject to recurrent attacks of follicular tonsillitis. Her menses were established at 17; about that time she had a severe attack of typhoid fever. For six months prior to the operation of oöphorectomy she had been bedridden. She was hopeless, dyspeptic, and anæmic in the extreme degree. Her neuralgic headaches, and ovarian pains were intolerable at each menstrual epoch. She readily accepted the proposal as to removal of the ovaries. The operation was borne courageously, and her convalescence was uninterruptedly good. Upon her return to her home in Baltimore she relapsed into her former despondent condition. She has not fulfilled my expectations as to complete cure, though she has improved physically.

Case 14.—Age 23; white; single. Was healthy until 13, when menstruation began. At first the recurrences of it were painless and regular. An interruption of four months occurred, and dysmenorrhœa, menorrhagia and ill health followed. Tormented by her physical pains and disqualification, and her inability to support her aged parents, she sought oöphorectomy as a last resort. It has brought about excellent health and capabilities.

Case 16.—White, aged 22; single. Unlike the preceding case, had led a life of luxury and ease. Her dysmenorrœal pains in defacation and general depreciation in health during five years, caused her family to seek the removal of the ovaries. Perfect satisfaction as to health, cheerfulness and comfort has come both to her and to her friends.

Case 27.—Age 39, colored; washerwoman; widow. Operation Oct. 8. Had one full term child and one miscarriage. This patient was operated on by me one year ago for a deep laceration of the cervix. While the parts healed well, she was not benefited as regards her distressing and disqualifying dysmenorrhœa. The appendages were removed. She is still in the hospital. All the indications betoken a happy issue out of her afflictions.

It is noteworthy that five out of six of these cases of chronic ovaritis were single, and that their ages range from eighteen to twenty-three years.

PYO-SALPINX.

The five cases under this heading all made good recoveries but one, which was a very unpromising one. Both ovaries and tubes were packed in one conglomerate mass in the posterior cul-de-sac; one of the tubes ruptured on removal, causing septicæmia. It is interesting to relate as bearing on the etiology of this disease, that every one of these cases was undoubtedly gonorrhœal in origin.

Two had been under treatment in our dispensary by Dr. W. S. Gardner, and the other three were ladies who were innocent victims to the viciousness of their husbands. I prescribed for one of the males a short time prior to marriage for gonorrhœa, and was greatly astonished not long after that event, to find him with a bride whom he had infected by the same disease. Six months later the uterine appendages were removed. The other two confessed to having transmitted it to their wives. One of the cases was an extremely critical one, since a pus tube had burst and discharged through the rectum three months prior to the operation. From that date to the operation the lady was disqualified for any household duty, though she had around her a large family. When operated on six months ago, she weighed 130 pounds; she now weighs 160 pounds, her weight when in former good health.

FIBROID TUMORS.

Two abdominal hysterectomies were performed for fibro-cystic degeneration of the uterus. The first was

Case 11.—The abdominal incision was 14½ inches long from the sternum to the pubis; the tumor weighed over twenty pounds. Its vertical circumference measured 23½ inches, and its transverse circumference 22¾. There was, in view of the very large pedicle, considerable difficulty in securing her against hæmorrhage, hence the intra-abdominal method of treatment would most likely have failed had it been resorted to. A full description of this case has already been published in the proceedings of the A. M. A. of 1891. The patient was unburdened, and health is now being enjoyed.

The second was a case of supra-vaginal hysterectomy for a fibro-cystic tumor of the uterus. This has been described.

Case 24.—The third case of fibroids gave the following history: Her first intimation of a tumor was October 18, 1890. While playing on the piano, she had a rush of blood which filled a chamber. This was the time of her menstrual flow. She bled alarmingly at each menstruation. Prior to operation she had bled continuously for a month. Diagnosis was intramural fibroids, chiefly occupying the posterior wall. The pelvis was well filled by the tumor. While

BALTIMORE CITY HOSPITAL—ABDOMINAL SECTIONS.

No. and Color.	Name.	Age.	Date.	Single.	Married.	Children.	Miscarried.	Disease.	Operation.	Drain.	Complications	Recovered.	Died.	Remarks.
1 W.	H. T.	30	Nov. 13, 1890.		M.	5		Retroflexion. Dysmenorrhœa.	Removal of both ovaries. Hysterorrhaphy.	No.	Stitch Abscess.	R.		Examination before leaving the hospital showed the displacement to have been corrected. Health restored.
2 W.	W. E.	38	Nov. 24, 1890.	S.				Ovarian tumor and dermoid cyst.	Extirpation of both tumors.	Yes.		R.		Right ovary distended with 2¼ gall. fluid. Nearly its entire surface was adherent to abdom. wall. On the left side was a dermoid cyst the size of a child's head, the pedicle of which was four inches wide. Recovery complete.
3 W.	H. L.	37	Nov. 28, 1890.	S.				Chr. ovaritis, dysmenorrhœa and hysteria.	Removal of both ovaries.	No.		R.		A working woman totally disabled from making a living; was anæmic, subject to dysmenorrhœal pains, vertigo and fainting fits. Health has been entirely restored.
4 W.	B. C.	46	Jan. 4 1891.		M.			Cancer of the ovary.	Exploratory laparotomy.	No.		R.		Large cancerous cysts studded the peritoneum and intestines. Ovaries had undergone malignant degeneration. Abdominal fluid was removed, the cavity flushed. Patient returned home in three weeks much improved.
5 W.	P. N.	47	Jan. 9, 1891.		M.			Subperitoneal fibroids.	Myomectomy. Oöphorectomy.	No.		R.		Had been bed-ridden for six mos., though sick for years. Uterus was retroflexed by a fibroid the size of a hen's egg, on the upper posterior aspect of the fundus. This was removed. A small fibroid located on posterior wall of uterus. Hence oöphorectomy. Result permanently good.
6 W.	R. S.	32	Jan. 28, 1891.		M.	5		Gonorrhœal pyosalpynx.	Removal of both ovaries and tubes.	No.		R.		On the fourth day after operation menstruation seemed to be at hand, and lasted four days. Made an excellent recovery, and has seen no show since.
7 B.	S. J.	21	Feb. 2, 1891.	S.				Gonorrhœal (double pyo-salpynx). Extensive adhesions.	Removal of both ovaries and tubes.	Yes.	Pus tube burst. Hæmorrhage very great.		D.	Patient died of sepsis on the third day. The whole of Douglass' cul-de-sac was denuded, and from this surface copious hæmorrhage ensued. Bleeding was arrested by packing with Iodoform gauze.
8 W.	S. A.	22	Feb. 9, 1891.		M.			Gonorrhœal salpingitis. Chronic ovaritis.	Removal of both ovaries and tubes.	No.		R.		Anæmia most pronounced; complexion waxy; general health very bad, so much so as to render doubtful the advisability of operation. The gravity of the case stated to friends. The results most satisfactory.
9 W.	S. B.	28	Feb. 22, 1891.		Widow.			Ovarian tumor.	Removal of tumor and other ovary.	No.	Slight stitch abscess.	R.		Made a complete recovery. Have seen her lately in good health. Has resumed her wonted weight and vigor.
10 W.	W. S.	50	Mar. 19, 1891.					Ovarian tumor. Peritonitis.	Removal of tumor and other ovary.	No.			D.	Patient called six weeks before operation, and was, in view of the great abdominal development, advised to accept immediate operation. When she arrived she was suffering with peritonitis. Death took place two hours after the operation, from surgical and chloroform shock.
11 W.	T. V. L.	48	Apr. 20, 1891.		M.			Fibro-cystic tumor of uterus.	Abdominal hysterectomy.	No.		R.		Incision 14½ inches. Tumor weighed 20 lbs.; its vertical circumference was 23½ inches and its transverse 22¾ inches. Treated stump extra peritoneally. Temperature did not reach beyond 99°, nor pulse below 80. Recovery was uninterrupted and complete.
12 W.	H. J.	21	Apr. 21, 1891.	S.				Chronic ovaritis. Dysmenorrhœa.	Removal of both ovaries.	No.		R.		Had been bed-ridden for over six mos.; had been a sufferer with Dysmenorrœa since 17, when her menstruation began. She gained in weight, and was cheerful for a while, but relapsed into the same neurotic state as before operation. Improved physically, not mentally.
13 W.	S. M.	35	Apr. 26, 1891.		M.	5		Uterineretroflexion. Abscess involving right tube and ovary discharged through rectum. Painful mass on right side of pelvis.	Removal of both ovaries, including the cellulitic mass involving the right ovary.	No.		R.		Hæmorrhage readily controlled. Blood removed thoroughly by sponges which had been packed in cul-de-sac. No drainage, no flushing. Temperature did not rise above 100°. Stitches removed on tenth day. Recovery rapid. In 5 mos. has increased in weight from 130 lbs. at time of operation to 160 lbs. Health excellent.
14 W.	A. B.	23	May 9, 1891.	S.				Dysmenorrhœa. Anæmia. Metrorrhagia.	Removal of both ovaries and tubes.	No.		R.		A factory hand who had been compelled to quit work on account of ill-health. Has been able to resume work. Is in good health and spirits.
15 W.	S. E.	28	May 11, 1891.		M.	3		Ovarian tumor of right ovary; left ovary had a cyst in it containing 10 oz. fluid.	Removal of tumor and other ovary.	No.	Stitch Abscess.	R.		Made an excellent recovery, except as to the delay from the stitch abscess.
16 W.	W. A.	22	May 20, 1891.	S.				Chronic ovaritis. Dysmenorrhœa. Anæmia.	Removal of both ovaries and tubes.	No.	Stitch Abscess.	R.		Elevation of temperature combatted successfully by Salines. Two stitches removed on the fifth day, and the others on seventh day, because of redness around them. Superficial suppuration continued two weeks; healing rapid. Thorough recovery.
17 W.	S. K.	20	June 3, 1891.	S.				Epileptiform spasms. Dysmenorrhœa.	Removal of both ovaries and tubes.	No.		R.		Menstruation begun at 15; since then had been at every recurrence subject to fits. A number of distinguished nerve specialists in New York and elsewhere had treated her. Massage, electricity, drugs, all alike failed. Recovery from operation excellent. Cure incomplete.

BALTIMORE CITY HOSPITAL—ABDOMINAL SECTIONS.—CONTINUED.

No. and color.	Name.	Age.	Date.	Single.	Married.	Children.	Miscarried.	Disease.	Operation.	Drain.	Complications	Recovered.	Died.	Remarks.
18 W.	V. M.	18	June 18, 1891.	S.				Acute mania. Dysmenorrhœa.	Removal of both ovaries and tubes.	No.			D.	Had periodical attacks of Mania, with menses, since first appearance at 15. Six mos. ago was in an insane asylum. A few days after operation acute mania set in. She died the eleventh day after operation.
19 W.	S. M. L.	25	July 4, 1891.		M.			Traumatic peritonitis. Retroflexion. Displaced and diseased ovary.	Removal of both ovaries and tubes.	No.	Cystitis.	R.		Uterus retroflexed and bound by adhesions in its malposition. Had cystitis. Was always in pain. Menstruation painful and irregular. Cause; a fall when 14 years old. Recovery complete.
20 B.	D. K.	42	July 18, 1891.	S.				Ovarian tumor.	Removal of tumor and the other ovary.	No.	Stitch abscess.	R.		Patient noticed the growth six years ago, but did not know what it was. It was claimed by her that menopause came on at 36, and growth was more rapid the last three years. When she left hospital the abscess had not completely healed. Recovery is complete.
21 W.	W. A. S.	16	July 20, 1891.	S.				Ovarian tumor.	Removal of tumor and the other ovary.	No.	Stitch abscess.	R.		Patient noticed her abdomen was growing larger when she was 12. She had her menses last winter several times, but the flow was scanty. Her periods were irregular. Had an uninterrupted and rapid recovery.
22 W.	L. C.	25	Sept. 1, 1881.		M.			Cancer of left ovary involving the intestines.	Exploratory laparotomy.	No.		R.		Found a large cancerous mass in the left side, involving the liver as well as ovary. Closed the abdomen. Recovered sufficiently to go home.
23 W.	W. E.	23	Sept. 2, 1891.		M.			Both ovaries cystic. The left mass of cysts displaced in posterior cul-de-sac, and adherent.	Removal of both ovaries and a fœtus of 6 weeks.	No.	Pregnancy.	R.		Examination disclosed enlarged and cystic ovaries. Her physician had probed the uterus and was satisfied she could not be pregnant. She had had three miscarriages in the first third of gestation. Determined after conference to remove the fœtus and continue operation. Result excellent.
24 B.	R. R.	27	Sept. 9, 1891.	S.				Intramural fibrolds. Dysmenorrhœa, menorrhagia alarming in extent.	Removal of the ovaries.	No.	Stitch abscess.	R.		Had expected to do a hysterectomy, as uterus was large and it was unlikely that the ovaries could be reached; but both were in front and easily removed. Patient had some metroperitonitis for several days, but made an excellent recovery.
25 W.	R. A.	33	Sept. 24, 1891.		M.	2	1	Retroflexion. Prolapsed ovaries. Dysmenorrhœa.	Oöphorectomy. Hysterorrhaphy.	No.	Stitch abscess.	R.		Had suffered for years with retroflexion and prolapse of ovary; was disabled for all duty. Removed both ovaries and stitched the uterus to the abdominal wall. Made a good recovery.
26 W.	M. O.	33	Sept. 26, 1891.		Widow.			Peritonitis. Hematocele, Abortion.	Exploratory laparotomy.	No.		R.		Time of operation, temperature 102°. It began to fall at once. In three weeks the exudates were removed. Has made a perfect recovery.
27 B.	C. M.	39	Oct. 8, 1891.			1	1	Chronic ovaritis. Dysmenorrhœa.	Oöphorectomy.	No.		R.		Nothing worthy of comment, save relief from pain and promise of complete recovery.
28 W.	S. M. L.	25	Oct. 18, 1891.		M.			Cyst in broad ligature.	Laparotomy for removal of cyst.	No.		R.		Same case as operated on July 4, 1892. Cyst of broad ligament containing serum removed. Entire relief from pain. Recovery uninterrupted. Is now sitting up.
29 W.	G. L.	32	Oct. 18, 1891.		M.		1	Extra-uterine pregnancy.	Laparotomy, removal of sac, with placenta and both ovaries.	Yes.	Mania of a mild type.	R.		Four months had scanty, irregular, and painful menstruation. She was compelled to go to bed one month ago. On opening abdomen a large sac in left iliac region strongly adherent to surrounding structres involving tube and ovary. Microscopic examination showed placental tissue: drain tube used 24 hours. Recovered.
30 W.	B. L.	37	Oct. 25, 1891.		M.	4	1	Pyo-salpynx.	Removal of both ovaries and both tubes.	No.		R.		Had a clear history of gonorrhœa; was under dispensary treatment three mos. Flushing was used; no drainage. Recovered without unfavorable conditions.
31 B.	B. M.	32	Oct. 27, 1891.		M.		1	Ovarian abscess.	Extirpation of abscess sac and other ovary and tube.	Yes.	Stitch abscess.	R.		Sac filled pelvis nearly to the umbilicus; was at every point adherent to uterus, intestines, or abdominal wall; was enucleated by the hands rather than the knife. Drainage tube used 24 hours. Her recovery is regarded as phenomenal.
32	W. M.	37	Oct. 29, 1891.		M.	3		Fibrocystic tumor of uterus.	Abdominal hysterectomy.	No.			D.	Tumor began to show five years ago. Since then has been suffering profuse hæmorrhages. Was supposed to be an ovarian tumor. Got through operation well. The stump secured by the Baker-Brown clamp. No bleeding. About the fifth day temperature up to 103°; pulse 150. Death took place on the seventh day from peritonitis.

I hoped to find the ovaries, due preparation was made for a hysterectomy. They were happily in front and were removed; not a drop of blood has appeared since the operation. She made a good recovery.

Case 5 was one of sub-peritoneal fibroids. The patient had been bed-ridden for six months, though sick and disqualified for all the duties of a wife for years. The uterus was retroflexed by a fibroma the size of a hen's egg, situated on the upper posterior part of the fundus. In addition to this there was a small intramural fibroid the size of a filbert, located

on the posterior wall at the junction of the body and neck. Myomectomy was done, and both ovaries and tubes were removed; she made a good recovery.

HYSTERORRHAPHY.

In two cases, No. 1 and No. 25, hysterorrhaphy was performed after the removal of the appendages for retroflexion of the uterus with chronic ovaritis and dysmenorrhœa.

The operation by suturing through the anterior uterine wall may well be considered obsolete. The first case I performed on November 13th, last, suturing through the stump of the uterine appendages, without scraping or otherwise injuring the uterine wall. The outer part of the sutures were cut off at the end of two weeks, and the remaining parts allowed to fall back into the abdomen.

In the second case, No. 25, the sutures were simply made to pierce (without tying) the ovarian ligament and brought through the abdominal wall opposite their respective insertions about 1½ inches from the incision, and tied over a bridge of skin one-half inch wide. In two weeks they were removed by cutting one side and drawing them out entirely.

Both cases, when discharged, were in excellent condition. The uterus in each case was well secured in its rectified position, as attested by several competent examiners. Further time is necessary to establish the permanency and value of these operations.

CYSTIC DEGENERATION OF OVARY, COMPLICATED BY PREGNANCY.

Case 23.—M., 23 years old, has had no full term children, but three miscarriages, during the first third of gestation. Patient had been subjected to considerable local treatment without avail. Her present trouble with the left ovary had been recognized during the past three years. The possibility of pregnancy was broached, but her attending physician said that he had lately been making intra-uterine applications, and hence was confident she could not be pregnant.

On opening the abdomen, the diseased ovary was readily verified, but the uterus was unduly large and the cervix was dilated with parallel bar dilator, so as to explore its contents. A fœtus of six weeks was withdrawn, the ovaries were removed. The subsequent history of the case was uneventful save that recovery was rapid and complete. The ovary on left side was represented in the thickened portion of the wall of a cyst the size of a walnut.

EXTRA-UTERINE PREGNANCY IN A DOUBLE UTERUS, REMOVAL OF SAC AND THE REMAINING OVARY.

Case 30.—Age 32, had been married fifteen years, but was without offspring. Since girlhood she had been regular with menstruation. For four months past her menstruation has been scanty and irregular and her general health miserable. One month prior to the operation, she was compelled to go to bed. When the patient was first examined in consultation with Dr. Wm. Gombel, of Baltimore, her attending physician, there was a hard resistent mass occupying the left side of the pelvis, pressing upon the rectum and causing intolerable agony. Laparotomy was determined upon. A large encyted mass, the size of two fists, occupied the posterior and lateral regions of the pelvic basin, pushing the double uterus to the opposite side. At the outset, in enucleating it, the blood contents escaped; the sac was shelled out and the pedicle ligatured. The right ovary was removed. The abdomen was flushed, the drainage tube inserted and the abdomen closed.

The double uterus was realized by sight as well as touch, it having been held up in the incision for a satisfactory recognition by all present. There were two distinct fundi, with deep sulcus between them. The cervix was single. The drainage tube was taken out in twenty-four hours. The patient during about ten days, although doing well physically, had an attack of mania. Providentially she was at no time unmanageable, though she was watched with the most assiduous attention by her nurse. She entertained two vagaries, and aside from them, was sane and logical. One was the constant dread that she was to be operated on by the doctor again, and when either of her attendants entered the room she was frantic with fright. The other departure was that she could hear her family talking in the next room. She would answer their supposed questions and plead pitifully that they be admitted. She is now perfectly sane, has gotten well of her stitch abscess, which followed the drain tube, and is out of harm's way.

A microscopic examination of the tissue of the sac, showed it to be placental.

STITCH ABSCESS.

This complication occurred nine times, a much larger number relatively than I have seen recorded heretofore; while no case proved disastrous, several were exceedingly annoying in delaying patients in hospital. They occur most frequently in cases where the drain tube has been used. The early opening of the abdominal dressings for any purpose, favors their occurrence. When the dressings remained intact for seven days there seemed to be greatest immunity from the stitch abscess. Dr. Welch says: "A coccus, which may appropriately be called the staphylococcus epidermus albus, is a nearly, if not quite constant inhabitant of the epidermis, lying both superficially and also deeper than can be reached by present methods of disinfection of the skin. The coccus is found frequently in aseptic wounds. It may be the cause of disturbances, usually of a relatively slight degree, in the healing of the wound, especially when drainage tubes are inserted. It is the most common cause of stitch abscesses in wounds treated aseptically and antiseptically.

DRAINAGE IN ABDOMINAL SURGERY.

Drainage was resorted to in but three cases during the year.

Case 2.—Ovarian and dermoid cyst—had a drainage tube in five or six days, and I am convinced it retarded her convalescence.

Case 28.—Extra uterine pregnancy—had a tube in less than twenty four hours. If I may judge of the necessity for it by the quantity or quality of the discharge through it, I should say it did no good. A small superficial abscess at the entrance of tube followed its withdrawal.

Case 32.—Ovarian abscess—had a drain tube in about twenty four hours. An abscess occurred at the site of its entrance. The quart of pus which was saculated in this case, was removed without an atomic part of it touching the peritoneum or the wounded parts, otherwise her fate would have been sealed, as was the case in No. 7, where the pus tube burst

and death ensued on the third day of peritonitis. Even in such a case as the latter, the most we could do, would be to thoroughly flush out the abdomen.

I am of the opinion that there is even too much flushing done; it is but seldom called for. A plentiful supply of fine properly prepared elephant-ear sponges, will do away with flushings in most cases and remove the necessity for drainage. They are efficient helps in keeping the abdomen free from infection. They can be utilized in keeping back the intestines, in occupying the cul-de-sac, in positions below the pedicle, in taking up blood or secretions, in staunching hæmorrhage, in separating adhesions, in protecting the intestines while closing the abdomen. The assidious personal attention of certain workers using the drain tubes, has caused them to escape the disasters, which have befallen the less careful and less skilful surgeons.

Nature's plan for curing the unsightly rents the surgeon makes when he opens the abdominal cavity, is to seal hermetrically the sacred cavity of the peritoneum, in twenty-four hours. This kindly and providentially comports with its sensitiveness and its fitness for the cultivation of germs of disease. Does not this prompt sealing of the peritoneum speak with unmistakable logic to the point, of striving hard for an aseptic operation and for securing immediate and absolute closure?

The oft repeated removal of the dressings of the patulous drainage tube must of necessity be a very great danger; surely it favors decomposition and invites germs. All surgeons are aware that after an anæsthetic, restlessness and jactitations are not wholly restrainable. It is easy to conceive how physical injury may accrue to the patient during this critical time, from these not at all innocent, yet smooth glass tubes.

I believe drainage is doing more harm than good, and therefore ought to be abandoned by the abdominal surgeon.

There is a dual personality as well as power concerned in all surgical work. The one is the surgeon, who skilfully meets and disposes of the crises in the more mechanical part of the work and therefore receives the plaudits of the multitude, the other, is the influence behind the throne, more potent than the throne itself, which reaches beyond the eye, the touch and the knife. I scarcely need say it is the modest, yet oft-despised laboratory physician, who is teaching us the hidden leaven of disease. Let us give him grateful recognition, for the pivotal facts and secret springs in recent surgical success. When he says bruised tissue is a paragon field for the cultivation of infected germs, let us heed the warning and cast aside the drainage tube.

Dr. Parkes says as to drainage: "Views and practices concerning drainage have materially changed even since the antiseptic era began. Our predecessors drained to permit escape of pus, which they knew would form. Until lately we have drained in order to prevent its formation. We seem now to be on the eve of an era when we need to drain but little or not at all. We resort to drainage now only of necessity, in septic or infected cases. In other cases we drain mainly from habit, or from fear. Indeed, when we start afresh, as it were, without previous infection, the practice of drainage is a confession of fear or of weakness, both of which are alike unscientific and unfortunate. It even seems to me that in many cases where all other aseptic requirements have been met, we do much more harm than good by the use of drains."

THE DRINK PROBLEM FROM A MEDICAL POINT OF VIEW.

BY FREDERICK HORNER, M. D.,

OF THE U. S. NAVY.

The definition of disease is "any alteration from a perfect state of health." When it pervades the whole system, as fever does, it is called a general disease; when it affects a tissue or special organ, disease is partial or local. When alcohol induces deliriumtremens, or *mania a potu*, inebriety, as a disease, answers to the first definition, and when inductive of gastritis, Bright's disease, insanity, etc., the second definition is applicable. The term inebriety, or alcoholism, has assuredly been adopted during the present century as designative, in medical nomenclature, of a disease of the human body. The incredulous may demand in what tissue or vital organs of the body is located the disease, and may require of us to state in medical, physiological and pathological terms the signs, symptoms and effects of this disease. In reply, the statement, based upon facts, to be presented is made that nerve and brain tissue and the vital fluid—the blood—are the seats of the disease of inebriety. While the exact locality may be imperceptible to the senses the microscope does reveal molecular changes in the nerve tissues and excess of fibrine in the blood;[1] the scalpel point may fail to touch the exact spot of brain tissue affected to show where the disease begins; but this cannot always be done in cases of insanity, epilepsy, or paralysis. In coup de soleil, and where individuals perish by lightning, the effects may be noted, such as the loss of consciousness, insensibility and fluidity of the blood, and yet the subtle cause producing instantaneous death may not leave a trace of harm or the evidence of lesion upon a single tissue or organ of the body. Again, a consumptive or cancer-stricken father or mother may have neither phthisis nor cancer developed in their offspring by heredity, and yet by the irreversible law of ativism these hereditary diseases will appear in some collateral descendant in another generation as surely as the iniquity of the fathers, according to the Bible, are visited upon the children. Some authorities define inebriety to be a disease of the nervous system, allied to insanity, characterized by an overwhelming impulse or craze for intoxicants—the effect of the excessive use of alcohol exerts a toxic effect on certain organs, beyond doubt—e. g., degenerative changes of the nerve substance of the brain, the victim loses the power of muscular coordination, there is paralysis of the will and perversion of the moral faculties. Prof. H. Newell Martin, of the Johns Hopkin's University, says "it is not strange that the liver often becomes diseased from a man taking alcoholic drinks, followed by fibrous degeneration; the true liver substance is crushed and killed, and what remains is a shrunken, hard, rough mass, well known to the pathologist as 'hob-nailed' liver. The mucous membrane lining the air passages is in a congested state. There is, also," he adds, "a

[1] There are also marked changes in the muscular structure of the heart; loss of power, attended by fatty degeneration, sometimes completely surrounding this vital organ with a dense layer of fat, and in extreme cases the fibres of the muscles of the heart turn to fat, inductive of dyspnœa, and the victim ultimately dies of dropsy.

peculiar form of consumption which is rapidly fatal, and is found only in drunkards." To two eminent American physicians, Drs. Albert Day and T. D. Crothers, may be awarded the credit of establishing beyond all questioning, the facts to prove that inebriety is a disease, and that "all the symptoms are incidental to the toxic effects of alcohol, marked by psychical and pathological changes and the inability of the patient to cease the use of spirits." Dr. Crothers asserts nerve degeneration occurs, then follow functional and organic disturbances. From hereditary causes there may be further proofs of organic degenerations, marked by an anæmia and a sudden insane impulse for intoxicants. In summing up the statistics this profound expounder of the subject adds: "Inebriety is the active cause of from 15 to 50 per cent. of all insanity, from 30 to 80 per cent. of all idiocy, from 60 to 90 per cent. of all pauperism, and from 50 to 85 per cent. of all crime." Dr. Albert Day, of Boston, in his late thirty-third annual report of the Washingtonian Home for the treatment of inebriates, says: "On the individual the effects of vicious alcoholic indulgence is disease of the body. Sooner or later it must come. Disease of the mind is not far off. It may be delirium or insanity; the moral sense is blunted. The man is dying, and if not restrained will soon be dead. Drunkenness is the scourge of our land, and the main secondary cause of its spread most certainly seems to be the false dietetic place of alcohol. Put back this perilous drug whence it came—into the medicine-chest and laboratory—and then a masterstroke will have been achieved to lessen the evil. The votaries of folly who spend the better half of the night in the halls of Bacchus and Terpsichore will at last dance on scorpions and swim in the river of misery and death, instead of pleasure. The effects of intemperance upon the patriotism of a nation is neither obscure nor doubtful. The man might as well talk of justice and mercy who robs and murders on the highways as he whose example is pestiferous and whose presence withers the tender charities of life and perpetuates weeping and woe. A nation of drunkards and drunkard-makers would constitute a hell." After a warning to the general public relating to the danger in following the drinking customs of so-called polite and refined society which now so generally prevail, Dr. Day concludes that "the interests of religion, our spiritual welfare and happiness, the happiness and safety of our families and of succeeding generations demand from us unceasing sacrifice to remove this enemy to good government, morals, and truth." In a monograph, "Our country, its possible future and its present crisis," by Dr. Josiah Strong, the author shows by reliable statistics that the use of intoxicants is more dangerous for this generation than it has been for any preceding one, and he asserts his belief that civilization must either destroy the liquor traffic, or be destroyed by it. "In the Philadelphia Hospital Dr. Formad found, in the dead-house autopsies, that of two hundred and fifty chronic alcoholists nearly 90 per cent. had fatty degeneration of the liver; 60 per cent. had congestion, or a dropsical state of the brain; the same number an inflamed or degenerated stomach, while not quite 1 per cent. had normal kidneys. Such eminent scientists as Richardson, Skae, Forbes, Winslow, Anstie, Parrish, Dodge, and others, confirm the fact that inebriety is in itself a form of insanity, and like all hereditary diseases is transmitted from parent to child as much as scrofula, gout, or consumption, and gives the least hope of a permanent cure unless treated according to the suggestions of modern medical science." Dr. Davis, of Chicago, on the occasion of the late National Temperance Convention on Staten Island, said: "Alcohol is a poison, and when taken into the system it is now pretty well demonstrated is not assimilated, and while passing through the body it disturbs the various physiological processes, and is finally thrown off through the organs of excretion unchanged. Hence, if not assimilated it cannot be a food, and as it disturbs every physiological process, it cannot be a medicine. Therefore, if alcohol is *not* nutritious, and serves no purpose as a therapeutical agent, then mankind should be so instructed, and its promiscuous use abandoned. This work can alone be done by the medical profession."

In connection with the physiological effects of one form of alcohol, viz.: chloroform, upon the brain, nervous and circulatory systems, a striking illustration was furnished by your ex-president, Dr. Bedford Brown, and published in 1860 in the *American Journal of the Medical Sciences*. Case of extensive compound fracture of the cranium in the person of a boy about ten years old, who was kicked by a horse, producing a compound fracture, with depression attended by copious hæmorrhage, with portions of lacerated brain adhering to the edges of the wound. The effect of chloroform in this case was to arrest the bleeding and diminish the pulsations of the brain, whose surface became pale and shrunken. Dr. Brown was thus led to conclude that it is an error to suppose that the congestion detected in fatal cases from the use of anæsthetic forms of the alcohol compounds is the cause of the fatality, but is rather the consequence of their toxic effects on the nerves presiding over the processes of respiration and circulation.

As to the unique surgical importance of Dr. Brown's case it will compare favorably with St. Martin's, reported by Beaumont, and to us considering the topic of inebriety, is suggestive how death so often occurs suddenly to the drunkard, which could not be otherwise explained. Surely the investigator in the sphere of the subject of inebriety, its cause, prevention and cure will become a great benefactor of mankind.

The treatment of inebriety is involved in the question of the drink problem from a medical standpoint, and here the homely adage applies: an ounce of prevention is better than a pound of cure. During my active naval medical service, I recall that in 1859, by act of Congress, the grog ration of the seamen of the American navies was abolished; sailors were allowed an equivalent in money, 25 cents per diem, for this ration, and since, the sailor's condition, physical and moral, has been improved; he no longer is tempted to acquire the habit of drinking. A like blessing has come to the people of Virginia, as at my town of Marshall, where under local option law all the saloons have been closed. The physician practices a like precaution to shield his patient from maniacal, if not criminal suicide, by removing the vial of laudanum from his bedside, and as Dr. Crothers aptly remarks, puts him in quarantine, where diet, medicines, baths, exercise, with all other means can be applied with military exactness, regulating his mental and physical surroundings, along

with the use of appropriate drugs, the bromides, phenacetine tonics, calomel globules, etc. Coffee, tea and milk should be given often and early, especially in the morning. "Fluid beef" as prepared by the Nutriment Company, of Chicago, in the form of bouillon or soup may be considered a most palatable form of diet. The coffee palaces have already accomplished wonders in England, to decrease the use of alcohol in that country, and to diminish the craving for intoxicants. Dr. Crothers informs us that to-day there are over a hundred asylums and hospitals in the world for the treatment of drunkards, but, as yet, not one in Virginia, and not one for the treatment of the inebriates of our army and navy. In proof of the needs of the latter, in the report of the Chief of the Bureau of Medicine and Surgery to the Secretary of the Navy for 1890, Medical Director Albert L. Gihon reports a death from suicide, the result of a self-inflicted wound upon the throat by a seaman suffering a furious attack of delirium tremens, as the consequence of a six days' debauch. Had this man been in a hospital for inebriates, he might not have come to so miserable an end. Finally, are we not right to assert, as to this question of the drink problem and its solution, that there is present now in America, a great battle going on, to decide whether the forces that are to govern in the affairs of our nation are to emanate from the homes or the saloons? If now the purpose of our government be to promote the general welfare and to ensure the public health, the home and not the saloon influence should predominate.

Dr. Benjamin Rush said that "a people corrupted by strong drink cannot long be a free people," and Dr. Hunter McGuire, in his address in Philadelphia on the "Progress of Medical Science, etc.," can exult and gaze with admiring enthusiasm on the efforts made by the medical profession during this nineteenth century to improve mankind, and to establish hospitals, dispensaries, homes for the maimed, and in every way encourage the usefulness of medicine. And will the members of the medical profession not seek to stay the curse of inebriety, and by example and teaching in the midst of their several communities, make another advance, as the American Medical Temperance Association, the British Medical Society, and the Association for the Study and Cure of Inebriety, invite you to do. They would have you to cooperate with them "to study and investigate the action of alcohol, as both a beverage and medicine, to determine the facts concerning alcohol; not to become propagandists, as the appeal urges, but as scientists eager to obtain facts and clinical experience, and as the only competent authority to determine the alcoholic problem," yea, for even a stronger motive, because, according to Dr. Carpenter, in his article in the *Review*, physicians, among the professions, head the list of the greatest number of inebriates. We may become the instruments to save some of our medical brethren from the wretched life and death of the drunkard. While you may never be called upon to encounter the pestilence as it occurred at Norfolk, Memphis and Shreveport, or to meet even worse enemies, as did Livingstone, Kane and Ambler, you may rescue some fallen brother, and restore him to a life of usefulness here and happiness hereafter.

TWO CASES OF TRAUMATIC TETANUS.

BY C. M. FENN, M.D.,
OF SAN DIEGO, CAL.

Suggested by your recent rèsumè and editorials upon the Etiology of Tetanus, I venture to recall two cases of the traumatic variety, which in the matter of treatment seem to have been in line at least with some of the more recent investigations and conclusions.

At the period of their occurrence, a quarter of a century ago, Gross and others regarded all treatment of the "obstinate disease" as empirical. Upon this subject he says, "there are, I presume, few surgeons who would be found to be so venturesome as to remove a limb on the approach of such a disease, and *none would certainly be foolish enough* (italics mine) *to attempt the expedient after it is fully established.*"

It is true the bacterial origin of the malady had not then been determined, if suspected, but the writer believed that a poison or irritant connected with the wound was responsible for the tetanic paroxysms and that early isolation of the diseased tissues was indicated. Possibly he builded better than he knew. But even now, with our present knowledge of a period of circulation, so to speak, and that the bacillus *per se* does nor enter the circulation, should we not more frequently employ the scalpel as an adjunct, at least, to anti-septic measures?

In case one, a little toe had been split by contact with a sailor's knife left on the deck of a ship. Tetanic symptoms were well marked and were not influenced by excessive doses of cannabis indica, a much vaunted remedy at that period. Quadruple doses were taken by mistake.

Rapid amelioration of the symptoms and ultimate recovery followed amputation of the phalanges of the offending toe.

The second case was also typical in its aspects, opisthotonos and other pathognomonic features following the slightest noise or draught of air. A blow from a wine bottle shattered had produced a lacerated wound of the tissues overlying the radial side of right forearm. The nature of the injury, coupled with intemperate habits of the patient, made it an unpromising case.

A semicircular incision to the bone was made on the proximal side of the injury and the two wounds were frequently dusted with sulphate of morphine. In addition to this, both were covered with a warm water dressing to which a solution of permanganate of potash was added betimes. These, the main features of treatment, were attended with success.

In the light of modern research we learn that a bacillus, known as Nicolaier's, is always present in typical tetanus; and that pure cultures of it can produce the disease. It is further stated that the bacillus loses its virulence in the presence of oxygen. Is not this true of many animal poisons and does it not explain the potency of potassium permanganate, which contains so large a measure of oxygen and parts with it so readily? A recent case of rattlesnake poisoning in this vicinity, yielded quickly to the application of a strong solution of this salt to the wound.

In the cases cited no special medication was used to counteract the effect of the ptomaines unless the topical application of morphine might be so considered.

Having removed the cause, the bacillus, the question arises, what antidote have we as against the ptomaines or toxines?

Concurring in your statement that the scientific completeness of the etiology of tetanus is exceptional, let us hope that THE JOURNAL will continue to discuss the subject with more particular reference to its treatment.

THE INFLUENCE OF THE RECLINING POSTURE IN FEVERS UPON THE PRODUCTION OF OTITIS MEDIA.

Read at a meeting of the Milwaukee Medical Society, Dec. 22, 1891.

BY H. V. WÜRDEMANN, M.D.,
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It is generally accepted as a truism that the most frequent mode for propagation of an inflammation from the naso-pharynx to the middle ear is by direct extension along the mucous lining of the Eustachian tube. Any hindrance to drainage of the middle ear and tube occasioned by occlusion of the nose or pharynx is also recognized as a prolific cause of Eustachian salpingitis and otitis media. This is particularly marked in children, as their naso-pharynx is quite small in proportion to that of adults. Hence, the relatively greater number of acute aural affections in young people.

While these are the usual methods, a factor which may be overlooked is sometimes the actual cause, and in other cases an adjuvant of the inflammatory process. The recumbant position in any febrile disease, accompanied by inflammation of the upper air passages, leads to the accumulation of secretion from the nose and mouth in the naso-pharynx, from which it is with difficulty expelled. The influence of gravitation is naturally most marked in the dorsal decubitus, a position usually assumed by very weak patients. The irritation induced by the decomposition of the retained mucus around the mouths of the Eustachian tubes and their mechanical stoppage is an efficient cause of the aural complication. [See also Burnett.[1]]

To repeat from a former article:[2] Even "normal mucus from the nose forms a fertile pabulum for the growth of microörganisms." Secretion remaining in the naso-pharynx soon decomposes, giving rise to suppurative inflammation of the neighboring delicate membrane lining the aural passages. "Wright[3] examined the nasal secretion of 10 healthy persons of different ages for bacteria. There were found in six cases, staphylococcus pyogenes albus, aureus and citreus; in three, micrococcus flavus desidiens; in one, bacterium tactis ærogenes; in one, pencillium glaucum; in one, micrococcus cereus flavus; in one, micrococcus tetragenus; and in three, some undetermined species. The numerical preponderance of suppurative cocci agrees with the results of others." Of course decomposed mucus is even more septic.

As it is often advisable that the patient be confined to bed in the course of la grippe or the exanthemata, this cause in the production of the aural affection must necessarily obtain. It is evident, however, that otitis media would not be so common a sequel of such diseases if some attention, in these cases, were paid to the removal of secretion from the naso-pharynx by a warm spray of Dobell's solution, salt and water, or some such simple means.

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[1] Burnett, Chas. H., "Acute inflam. of the Middle Ear." Internat. Clinics, July 1891, p. 345.
[2] Würdemann, H. V., "Acute Suppur. Middle Ear and Facial Paral." Ophth. Record, Dec. 1891, p. 211.
[3] Wright, Bacteriol. World, July 1891, p. 525.

A SKETCH OF MR. LAWSON TAIT AND HIS WORK.

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In the following sketch an attempt will be made to present to the American physician some information of the life and work of Mr. Lawson Tait. The suggestion arose from the oft-repeated inquiry, which I have heard, to know more of the man who has written so well and worked so successfully.

At the time the subject of this sketch appeared on the field of practical surgery the harvest was ripe, and his genius, which was untiring energy, quickly gathered the fruit that had long waited a reaper. The medical profession have gladly welcomed the gathering of his golden sheaves, which have grown into ripened stacks. Mr. Lawson Tait was born in 1845, in Edinburgh, Scotland. He is the only surviving son of Archibald Campbell Tait. His parents died many years ago. Mr. Tait was admitted into the Heriot Hospital school at 7 years of age. He early showed marked mental capacity, and while at this school he won a scholarship which entitled him to be sent to the University of Edinburgh, where he studied the arts and sciences, and finally medicine. He began the study of medicine at 15 years of age, and was graduated at 21 as a Fellow of the Royal College of Surgeons of Scotland. During his medical studies he was under the training of a young surgeon of much promise, Alexander McKenzie Edwards, who was the favorite pupil of Sir William Fergusson. But Mr. Tait will be best remembered as the favorite student of Sir James Y. Simpson. Simpson was the greatest gynecologist of his day, and it is not strange that Mr. Tait should imbibe the views and be impressed with the teaching of a great man like Simpson. Simpson was one of the great original thinkers of his age, and also a practical observer, and this logical force of circumstances destined him to be a foremost leader in gynecology. Mr. Tait seems not only to have grasped Simpson's teachings with benefit, but immediately carried the key of progress into new fields. About this time a sad event occurred to the world, as well, no doubt, to the hopes and aspirations of Mr. Tait. It was the sudden death of the famous Simpson. With unfeigned sorrow the medical world beheld this great man fold his cloak of death about him and pass the gate that stands ajar for all. As Mr. Tait's beloved teacher was dead, he decided to leave Edinburgh. He went to reside at Wakefield as house surgeon to a hospital. We will now pause to consider some important matters in 1867, when Mr. Tait was 22 years of age, and beginning his surgical work in the Wakefield hospital. Up to 1860 the condition of abdominal surgery was not very encouraging. The best statistics which I have been able to observe records that ovariotomy was performed some four hundred times from the days of McDowell until 1860. The mortality was at least 45 per cent. Such frightful mortality would appall even a stout heart. Almost half the women died from the operation. From 1860 to 1866 Mr. Tait was a student in a school

known the world over for its original and progressive men. In short, history hints that McDowell himself received the suggestion of opening the abdomen to remove tumors from the Bells of Edinburgh, where he was listening to medical lectures. From the Bells the views passed on to Lizars, so that the Edinburgh school was in the head and front rank of abdominal work. Abdominal section must have been carefully discussed by the professors of the school from 1860 onward. Mr. Tait states somewhere in his writing that while he was a student their boyish debates often turned on the question, "Is ovariotomy justifiable?" and he notes that the conservative element among the students was so strong that the decision was nearly always against performing the operation. Two points can be gleaned from students' debates. The first is, that they will debate questions which their teachers discuss; the second is, that the students will decide as their teachers have instructed them. So we can reasonably conclude that during Mr. Tait's student days the Edinburgh school held an unfavorable view toward ovariotomy. But whether Mr. Tait resolved to follow the course laid down by his celebrated teachers or not, we find that circumstances at the Wakefield hospital led him into performing ovariotomy. It appears that at this institution Mr. Tait was allowed, by grace of his seniors, exercise of judgment as to the performance of operations. Into the hospital came women with large tumors, which were carrying them swiftly onward and swiftly downward. These women appealed to Mr. Tait for aid. Mr. Tait, seeing that the cases were doomed without surgical interference, operated, I understand, on some eight to ten during three years. The report runs that he saved about two-thirds of the cases. A mortality of only one-third was a vast improvement over other years. In 1870 it appears that Mr. Tait had decided to follow the surgical diseases of women for a life-work. He concluded to remove to Birmingham for a wider field of labor. Just before leaving Wakefield he married a lady of that place. Of her the least we can say is that she is a gentle and sweet woman. Her amiable disposition is her characteristic, and she wins warm friends wherever she goes. She is a pleasant and an entertaining conversationalist. Mrs. and Mr. Tait are a typical example of a happily wedded couple. They are both exceedingly fond of and attentive to each other. They are the dearest kind of friends, and spend much time together in driving and traveling. Our ideal of the man is raised when we see him bestowing such devotion on the companion of twenty years.

In the summer of 1870 Mr. Tait went to reside in Birmingham. As a young man of 25, he had shown himself to be possessed of courage. To this fearlessness I would call especial attention, as one of the characteristics of Mr. Tait. He had courage bold enough to follow out his convictions. His courage had already enabled him to save about two-thirds of his cases which were doomed without operation. He saved them by the dreaded abdominal section with its frightful mortality. Mr. Tait is a public-spirited man, and a few months after he arrived in the city he formed the acquaintance of George Dawson, a leading thinker of Birmingham. The acquaintance of this able man no doubt influenced Mr. Tait's life, for they were intimate and warm friends until Dawson's death, some years ago. Though Dawson was a regular officiating Congregational minister of wide reputation, and a frequent lecturer in different parts of the country, he established a newspaper called the *Morning News*, and Mr. Tait joined the staff. No doubt it would be interesting to read Mr. Tait's articles of twenty years ago, but we can conclude that the articles had originality and merit, or they never would have been accepted by Dawson, who was a keen critic and an exacting judge of journalistic work. We know personally from Mr. Tait's many kind references to the remarkably gifted Dawson that their friendship was a bright spot with happy memories. Such deep and long-continued friendship with gifted minds mold men's character by inscrutible increments. Mr. Tait had been in Birmingham but a short time when he demonstrated his wisdom by joining a movement to found a woman's hospital. With the accomplishment and success of this institution his name is inseparably identified.

We here consider Mr. Tait's position relative to operative gynecology. He has always been an active member of medical societies. He is a master of clear English expression, and when he debates he strikes right at the core of a subject. In fact, his remarks are direct and to the point. His statements appear in a declarative attitude, and each statement contains a challenge of accurateness. His enthusiasm is contagious and his aggressiveness stimulates opponents. He had not long lived in Birmingham before the medical societies began to listen to his new ideas on operative gynecology and journals began to print his views. It is needless to say that the English medical men met these new views with keen opposition, but curiously enough his new ideas were received with more liberality in the States. Three-quarters of a century will yet cover the great epochs of gynecology. The first epoch in this branch of medicine was when McDowell performed ovariotomy. Sir Spencer Wells made another era by his systematic labors in abdominal surgery. A distinct gynecological epoch arose when Sims began to pull back the perineum with his bent spoon. Another great epoch was created in gynecology in 1872, when Battey, Tait and Hegar came forward almost simultaneously and independently with a new operation. Curiously enough, these men lived about as far apart as civilization would allow. The new operation was the removal of the uterine appendages. Battey, of Rome, Ga., in 1865 "conceived the idea of producing an artificial menopause, the remedy of disease," and published his views in 1872. On August 17, 1872, Battey successfully removed the appendages. Mr. Lawson Tait, in February, 1872, removed successfully an ovary with an abscess in it about the size of a pigeon's egg, and he claimed that it was the first record in surgery where a small ovary was removed for pain. On August 1, 1872, he successfully removed both ovaries for persistent hæmorrhage. In the early part of August, 1872, Hegar removed the appendages, but the patient died. The above record shows the remarkable coincidence of widely different men and operators, independently performing the same new operation in the same year and about the same time. As electricity differs in its application in telegraphy, in lighting, and in therapeutics, so the removal of the uterine appendages differed in its application to disease. This same operation by Battey, Tait and Hegar has progressed in three different directions with three different results. Battey's operation limited itself to the neuroses mainly; Tait's operation

mainly involved the removal of the tubes, and Hegar's operation attempted to arrest the growth and hæmorrhage of myoma. The object of the operation was, 1, to remove organs incurably diseased (Tait); 2, to arrest menstruation (Battey); 3, to control uterine hæmorrhage (Hegar). From this time on Mr. Tait began to show his specimens at medical societies and to advocate the removal of diseased appendages. At first he met with little support and much incredulity. A very striking expression of the subject may be illustrated by a debate which occurred in London in 1881, in which Mr. Tait was endeavoring to show, by his numerous specimens obtained from operations, that pyosalpinx was not an uncommon disease. In this congress Sir Spencer Wells arose and said: "I have only seen one such case in my life. I suppose they all go to Birmingham."

In 1873 appeared his work on the pathology and treatment of the diseases of the ovaries. The production gained for him the Hasting gold medal prize. This prize was presented to him at the British Medical Association by Sir William Fergusson in 1873. His work on the ovaries is remarkably original. It shows a large amount of personal investigations. It has gone through four editions.

As the book appeared at a period of radical changes in the methods of treatment of ovarian disease it became very widely read. It no doubt materially modified the course of surgeons in a marked degree, and stimulated progress in pelvic surgery. His large experience with human ovaries enabled him to produce one of the most practical and valuable books on this subject. Mr. Tait made steady progress in gynecology, and in 1877 published his work on diseases of women. A second edition appeared in "Wood's Library" in 1879. This work at once placed him among the front rank of gynecologists. This book was bold, concise and original. Any reader could readily see that its author was progressive and practical. In his preface of that book, twelve years ago, he made a plea that any effort to extend an acquaintance with diseases of women should be received with patience. But I can well remember that the book did not entirely escape ridicule and abuse the first five years of existence. During the next five years it steadily gained in favor. I always looked on this book as being the most unique of its kind. It carried a contagious enthusiasm with it and had a very fertile power of inducing men to think. The work is not at all out of date, and can be still read with pleasure and profit. The book is systematic, and yet lacks dry classification. It is interesting to note that the author has progressively modified some of his opinions through increased experience. The work is vigorously written and is a typical example of a man's own experience and views put in a condensed and attractive form.

(To be Continued.)

The use of cocaine in the urethra is attended with more risk than when applied to any other part of the body. It should be positively forbidden in the recently cut or denuded urethra.—*Ex.*

THE International Dermatological Congress of 1892 will meet in Vienna, on September 5th to 10th. Dr. Prince A. Morrow has been appointed secretary of the Congress for North America.

DOMESTIC CORRESPONDENCE.

PHILADELPHIA LETTER.

The College of Physicians of Philadelphia, held its annual meeting January 6th, for the election of officers. Dr. S. Weir Mitchell was re-elected President, Dr. J. M. DaCosta, Vice-President; Dr. Chas. W. Dulles, Secretary; Dr. Charles Stewart Wurts, Treasurer, and Dr. Frederick P. Henry, Honorary Librarian, for the year 1892.

The Directory for Nurses has maintained its successful course during the past year, paying all expenses and contributing a surplus to the expenses of the College. During the year, special meetings devoted to Ophthalmology were held by Fellows of the College interested in this department, at which valuable papers were read, and patients and specimens were exhibited. At an early date, it is expected that a number of Sections of the College will be formed for the advancement of special departments of medicine, as the Council has this now under consideration. At this meeting, a communication was read by the Secretary, contributed by Dr. Gregorio Fedell, of Rome, Italy, entitled "A Rare Type of Malarial Fever," the author believing that the malarial manifestations observed by him in the reported cases constituted a peculiar type of the affection, which was not curable by quinine alone, and only yielded to a combination of quinine, zedoary root, camphor and ammonia.

Dr. Frederick A. Packard read a report of "Cases of Acromegaly," and presented a patient with enlargement of bones, constant headache, morbid somnolence, and the characteristic appearances of this interesting affection which has been termed "Maladie de Marie."

A specimen was exhibited of acute lepto-meningitis, which, from the general distribution of lymph over the convexity of the hemispheres and the base, and over the cerebellum, and from the clinical history was considered by Dr. Frank Woodbury, who presented the specimen, as infectious in origin and probably caused by influenza. The patient was 25 years of age, single; he was a robust man, whose work was that of stone cutting, which kept him out of doors. Upon returning from his daily work in his usual health, he was seized, Dec. 24th, with a chill, severe headache, backache, vomiting, fever and delirium. He was brought into the Medico-Chirurgical Hospital on the fourth day, and died two days later. There was a temperature of 104° on admission in the afternoon, but, after the administration of two ten grain doses of acetanilid and applying ice to the head, it fell to 100°. In the morning it again rose to 103½° and was 102½° the same evening; during the night he died. There was no eruption upon his body. While under observation he was actively delirious, talking and trying to leave his bed; he was very deaf in both ears, and his left eye was insensitive to light; pupils moderately contracted and sluggish with very little response to the light. Dr. Woodbury believed that the existing epidemic might be fairly assumed to be the cause of the lepto-meningitis, since pneumonia is frequent in influenza, and there is a close relationship between the microbic etiology of pneumonia and meningitis. Moreover, the ordinary causes of meningitis were excluded in this case. He considered it almost identical in appearance with the lesions of cerebro-spinal fever, in autopsies made by him in 1873; and this is of especial interest since the pathological relations of influenza are by no means established, and the possibility of an outbreak of cerebro-spinal fever following influenza has already been suggested. The exceptionally mild and damp weather during December was very favorable to the prevalence of malaria and infectious diseases.

Dr. Turner, Registrar of the City Board of Health, has just

issued his annual report, for 1890. In it a largely increased mortality is shown towards the end of the year.

Dr. Turner states that during the past five weeks, there have been in this city, 199 deaths from the grip alone; that is, fifty-five more victims than are credited to influenza during the epidemic of 1890. About 1,300 deaths were caused by it in a period of seven weeks during the early period of that year. From the 1st of December to January 2, there were 1,504 deaths from influenza and other causes which develop from it, and which are made more pronounced and dangerous by reason of the prevalence of influenza, such as pneumonia, consumption, bronchitis, heart disease, old age and paralysis.

The following table will show the ravages made among the very young and the aged during the past five weeks by influenza and other causes which it influences:

NUMBER OF DEATHS AT DIFFERENT AGES,
From Infancy to 100 years.

Cause of Death.	Under 10 Years.	10 to 15	15 to 20	20 to 30	30 to 40	40 to 50	50 to 60	60 to 70	70 to 80	80 to 90	90 to 100	Tls from Causes.
Influenza	22	1	0	3	7	18	16	35	62	29	5	198
Pneumonia	155	4	5	25	44	53	66	91	93	40	2	578
Consumption	4	3	24	88	58	42	35	19	11	0	0	284
Old Age	0	0	0	0	0	0	0	8	34	56	8	106
Bronchitis	59	0	1	1	3	2	8	17	16	7	1	115
Heart Disease	12	1	5	5	14	14	27	29	46	14	0	167
Paralysis	3	0	0	1	2	9	16	19	6	0	0	56
Totals at different ages	255	9	35	123	128	188	168	218	258	146	16	1401

From these seven causes alone, Philadelphia has had an average death rate during those five weeks of 300 4-5, or almost as large as the rate from all causes during October of 1890. A singular coincidence is that while the total number of deaths for each of the past two weeks was 718, the total deaths for the first week in 1890 were 718. That figure is the high water mark during the present epidemic, but in 1890 the total number of deaths in one week, in the latter part of January, reached 777. Up to the last week of June there had been 666 less deaths than during the same period of 1890. But in the last six months of the year the death rate began to increase rapidly, and we end the year with 1,635 more deaths than occurred in 1890. In other words, the increase during the last six months of 1891 over the last six months of 1890 was 2,301. This increase is almost wholly due to the grip and the diphtheria.

The effects of the epidemic of 1889-90 did not disappear until the end of March, 1890. In 1891 it had a moderate run from January to June, but during those six months there were only 102 deaths caused by it directly. As it began earlier this year than it did in either 1889-90, or the winter of 1890-91, it is believed that it will disappear earlier.

Here is a comparative table of the deaths during the epidemic of 1890, and those during the past five weeks:

	January 5 to Feb. 8, 1890.	Dec. 5, 1891, to Jan. 2, 1892.
Influenza	107	198
Pneumonia	438	578
Consumption	386	284
Old Age	136	106
Paralysis	59	56
Heart Disease	104	167
Bronchitis	60	115
Totals	1290	1504

In the same number of weeks the present epidemic has taken off 214 more victims than did its predecessor in 1890.

The present epidemic has worked much in the same manner as did that of 1889-90, and the majority of its victims have been over 50 years of age.

The Superintendent of the State Asylum for the Insane for the Southern District, at Harrisburg, in his annual report, just issued, ascribes influenza as the cause of insanity in six cases received during the year. The newspapers contain accounts of several suicides during temporary insanity induced by the same cause.

Prof. Da Costa also had something to say at his clinic at the Pennsylvania Hospital, Dec. 19, with regard to the prevailing epidemic. He presented cases illustrating different types, and compared this outbreak with that of two years ago. At the outset, he was quite positive in denouncing the use of the term "grip," or "la grippe," which is merely a popular French expression. He hoped that physicians would not only refuse to employ it themselves in speaking of or reporting cases, but also discourage its use in common language. The proper title for the present epidemic is influenza, and by confining ourselves to the use of this name we are brought into relation with previous outbreaks of the disease, thus facilitating comparison and clinical study. Physicians should discountenance eccentricities of nomenclature, which only cause confusion and lead to misunderstanding. The same types are seen this time as before—the nervous, the gastro-intestinal, and the catarrhal, with many intermediate forms. The fever is more of the continued type, lasting, with evening exacerbations and morning remissions, the fever ranging from 100° to 103°, or even 104°, for several days, though high temperatures have been rare. The absence of eruption and usual signs of bowel disorder, distinguish these influenza cases from those of typhoid, which in many respects they otherwise resemble. In many instances slight albuminuria, with hyaline and epithelial casts, has been detected. In the present epidemic there is the same severe headache, with muscular pains and tenderness, with less backache than in the last; but there is more restlessness, and, in addition, we have marked sweating at night. There is less affection of the nose and eyes, and more catarrh of the larynx and bronchia. The prostration of the muscular system and the cardiac weakness noticed in the last epidemic are also manifested in this, though in a less degree, and the whole course of the malady, as the rule, is milder. The fever runs its course usually in four or five days, but it may be a week or more, and it leaves the patient in a state of depression from which he may be months in recovering. The chief reliance in treatment, according to Da Costa, is quinine, stimulants in moderate quantities to sustain the circulation, chloride of ammonium for the catarrh, and nourishing food frequently, given in the form of broths, etc. Depressing agents should be avoided if possible, and when any of the newer antipyretics are given its effects should be carefully watched. Antipyrin and similar agents can only be safely administered in these cases by a physician and under his constant observation. The cardiac weakness and slow action of the heart may persist, and for this there is no remedy equal to strychnine. For the relief of the muscular pains, Prof. Da Costa uses small doses of phenacetine (grs. 3) with quinine (grs. 2) in capsules, every two to four hours; and also employs counter-irritants. It is an interesting question whether these joint cases are due to the poison affecting the spinal centers. The endocardial murmurs which are common are not the result of endocarditis, but are functional and connected with the fever process. The evidences of renal disorder soon disappear, but convalescence is prolonged. He concluded with the advice: Give up early; do not go out too soon.[1]

The Annual Oration before the Academy of Surgery, was delivered January 4th, by Dr. Thos. G. Morton, who took for his theme, "The Progress of Surgery in 1891." As the address was cyclopædic in character, covering most of the principal surgical work of the year, it is impossible to summarize it satisfactorily. He began with a tribute to Lister, who by his teachings made it possible to progress further in surgery than was deemed possible by surgical authorities pre-

[1] Clinical lecture in *Medical News*, Jan. 2, 1892.

vious to the introduction of modern wound treatment, and indeed many of our recent triumphs could not be achieved without antiseptic methods. In gunshot wounds of the brain, he advocated drainage, and reported a case in which a rubber drainage tube had been passed directly through the right hemisphere along the track of a ball which had been extracted by means of a counter-opening with a trephine. The patient died, but the results of irrigation and drainage were sufficiently good to warrant pursuing the same method of treatment in future with prospects of success, if performed early.

In regard to linear craniotomy for microcephalus, a case of marked improvement was referred to, occurring in a child 3½ years of age, in the hands of Dr. Wm. H. Morrison, of this city. The treatment of spasmodic facial neuralgia, as advocated by Dr. Edmund Andrews, of Chicago, was referred to with approval. Most cases of facial neuralgia are benefited by operation. In one case he had known twenty years to elapse without recurrence of the pain. In operating upon recurring neuralgias, the tissues in the neighborhood of the original wound are opened up, and surrounding structures are torn out, just as is the bulbous stump of the nerve, if found. This is practically the process advocated by Dr. Andrews. Metatarsal neuralgia or painful affection of the foot, first described by Morton, was next mentioned. Cases of this kind are often mistaken for gout or rheumatic, perhaps hysterical, disorders; but in typical cases, no treatment will relieve except that advocated by Morton, of amputation of the joint of the fourth toe. In gunshot wounds of the abdomen, early laparotomy and careful exploration was earnestly defended, as it does not materially increase the risk to the patient, and affords the only means of saving life in many cases which would otherwise perish with peritonitis. Laparotomy for intestinal perforation in the course of typhoid fever was advocated, with the condition that it be performed as promptly as possible. A case was referred to, done by Morton in 1887, which he believed to be the first operation in this country for the repair of a perforated, typhoid ulcer. Unfortunately it was delayed for many hours after the accident had occurred, but the operation was well borne and in no wise hastened the fatal termination. In appendicitis he practices early laparotomy and extirpation of the appendix vermiformis, and advocates operation between the attacks in cases where recurrences have several times been experienced, especially if a tumor and tenderness persist in the appendix region. Macewen's operation for aneurism was discussed, and a case reported and patient presented, when it had been performed by Dr. Morton without success. He deemed it worthy of further treatment, however. Congenital club-foot he divides into *simple* (deformity limited to soft parts) and *complicated* (accompanied by partial or complete displacement of the astragalus), the latter requiring the partial or complete excision of the dislocated and deformed bone. Later on in life, there occurs a combination of these two, with more or less deformity. The form of operative treatment to be adopted in the inveterate deformities is that in which the foot can be placed and retained without any effort in an easy, right angled position with the leg. This can be better secured and with less serious injury, with the knife than by the aid of powerful levers and screws, which are still used by some surgeons for breaking the tarsal bones into position. Mechanical apparatus should not be depended upon to overcome deformity subsequent to operation, but simply to retain the foot in a normal position after the distortion has been corrected. Even after operation, such cases require careful looking after for months or even years.

In mammary cancer he advocated early extirpation and repeated operation. Return after removal has been the rule in the experience of Dr. D. Hayes Agnew, who writes, "neither the knife nor caustics cure mammary cancer." Eleven years had been the longest time that any patient, in Dr. Morton's experience, had survived the operation; but it should be performed in order to relieve pain and make the patient more comfortable and thus prolong life.

There was present at the same meeting a medical missionary, Dr. R. H. Nassau, who had lived thirty years near the west coast of Africa. He was invited to contribute some of his observations, and made some interesting remarks. He said that strangers visiting the equatorial region, were liable to suffer either with severe forms of remittant fever (malignant bilious remittant like the Panama fever) or to have boils and abscesses tending to recur annually, at the beginning of the rainy season. Deformities are common, such as club foot; extra fingers and toes are not rare; elephantiasis of legs and scrotum is also common. Tumors, bursal, fibroid, and abdominal, (the latter occuring in women and probably ovarian) are very frequent. Mammary abscess in nursing women he had often seen, but could not recall a single case of carcinoma of the mammary gland. Gynecological disorders are very prevalent, from the laborious occupations of the women; from carrying burdens upon their heads, and especially from maltreatment during and after confinement.

Syphilis and venereal diseases were not uncommon, if not introduced by white men; they were rendered far more prevalent than they were before, from all that he could learn from the natives. Insanity receives no treatment, except if the patient is troublesome he is abandoned in the woods or thrown into a river. The sleeping sickness, which terminates fatally after several months stupor and somnolence, he attributes to the use as food of Cassava obtained from a variety of the Jatropha Manihot, or Sago palm, growing in that region of the world, which he says is a poisonous variety. The disease therefore may be classed among dietetic affections, if he is correct in his explanation, and not unlike poisoning by mush-rooms, which are also used as food and sometimes are poisonous. This is a subject worthy of further investigation both from a physiological and a therapeutical standpoint.

At a recent meeting of the Philadelphia County Medical Society, Dr. Willard presented a series of histories of injuries of the cervical vertebræ. One case was a boy about 13 years of age, who had fallen 30 feet upon his head. The third cervical had been fractured, but the displacement was so moderate in degree that the cord was but slightly pressed upon, and neither sensation nor motion were seriously impaired. A plaster of Paris encasement was applied so as to fix the head, neck, shoulders and thorax. Extension and counter-extension in a horizontal position was maintained by weight and pulley for six weeks. The boy, a year afterward, had limited motion in the direction of rotation to the right, but in other directions he could bend the neck with ease and comfort.

Another case was a boy who, in diving, struck his head violently against the bottom of a pool. After his recovery from the shock the symptoms were negative. A few hours later, there was impairment of motion and sensation in one arm, and in other parts of the body. This was evidently due to hæmorrhage within the spinal canal and consequent pressure upon the cord. He recovered perfectly in a few weeks under extension and rest.

Another case was that of a boy who fell through an elevator shaft, striking upon his head. Upon recovering from shock he was able to walk home, although there was considerable pain in the neck. The head could be rotated toward the right, but not toward the left. There was a prominence in the pharynx opposite the second, and the atlas was apparently displaced backward. Fracture of the odontoid was diagnosed. On the following morning, the patient was so well that he endeavored to go to his work. A few hours

later, however, he became unconscious, and died ninety hours after injury. The odontoid was found to have been broken off directly across its base. There was also a large fragment broken off the longer vertebra. The odontoid ligament had not been torn, which prevented further displacement and pressure.

Another case was that of a man who fell, completely crushing the posterior part of the bodies of the vertebra, including the lamina, from which death resulted in a few hours.

These cases show that the prognosis of the cases of broken neck depends very largely upon the amount of injury primarily inflicted upon the substance of the cord itself.

The Board of Health of the City of Philadelphia, on motian of Dr. Ford, adopted a resolution, January 6, petitioning the Senate and House of Representatives of the United States for the establishment of one or more stations for the registration and humane treatment of persons suffering with leprosy in this and other States.

The Philadelphia Cremation Society reports fifty-one incinerations for last year, an increase of 25 per cent. over the year previous. A resolution was adopted at the annual meeting, recommending the passage of a law requiring the cremation of the bodies of persons dying with infectious and contagious diseases.

Messrs. J. B. Lippincott announce a new medical monthly, *The International Medical Magazine*, with Dr. Judson Daland as managing editor. A good corps of collaborators is promised. The first issue was to have appeared early this month. One of its features is a department upon forensic medicine, under the direction of a member of the Philadelphia Bar, L. D. Beuleth, Esq. "Of the making of new books there is no end."

We have recently lost Dr. Samuel R. Knight, Superintendent of the Episcopal Hospital of this city for many years, and a member of the County Medical Society, American Medical Association, and other societies, where he had many friends. Dr. A. H. Gerhard, Professor of Physiology in the Medico-Chirurgical College, who had been in delicate health for several years, also died last month, with œdema of the larynx, the result of influenza. He was of a genial, though retiring, disposition, and had many warm friends.

NECROLOGY.

E. J. B. Statler, M.D.

AT his residence, Marshalltown, Iowa, Jan. 1, occurred the death of Dr. E. J. B. Statler, from lung fever and other complications, aged 65 years.

He was born at St. Thomas, Franklin Co., Pa., was educated at Jefferson Medical College, Philadelphia, graduating in 1851; was married to Miss Sarah J. Kemp in 1847, who now survives him, by whom there are six children: Benj. E., Wm. E., Mrs. F. W. Wells, Mrs. Geo. W. Beasley, Mrs. W. T. Utz and Miss Nellie Statler. Dr. Statler came to Iowa, locating at Iowa City in 1856, and at Marshalltown two years later. He went into the army as assistant surgeon of the Twenty-eighth Iowa volunteers, and was afterward made surgeon of the Thirty-eighth Iowa infantry, being in the service two years and a half. On his return he was elected Mayor and served one term. He was a kind-hearted, generous man.

The funeral occurred Sunday afternoon from his late residence, Rev. Dr. Rhea officiating, assisted by Rev. William Bryant, and was largely attended.

MEDICAL DIRECTOR Henry O. Mayo, U. S. N., retired, died at his home on Fifth Ave., New York City, on Thursday, December 31, aged 71 years. He was a native of New York, and was appointed from that State in 1846. He became medical inspector in 1871, and director one year later. His retirement took place a little over six years ago, since which time he has made New York City his abode. His family is one which has been well represented in the medical fraternity.

DR. SAMUEL WALDO HART, of New Britain, Conn., died December 31. He was a native of that town, born there May 22, 1825. He was a graduate of the old Berkshire school, and an honorary M. D. of Yale College in 1855. He was elected mayor of his city for five terms beginning in 1872. He was an honorary member of the State Medical and Hartford County Societies.

DR. FREDERICK BEDFORD, of New York City, died December 28, aged 54 years old. He was the son of the late Prof. Gunning S. Bedford, one of the coadjutors of Dr. Valentine Mott, in the founding of the Medical Department of New York University, from which school Dr. Frederick Bedford graduated in 1859. He was one of the founders of the New York County Medical Association and a member of numerous other organizations. His special predilection in practice was for obstetrics, in which branch he had been clinical assistant in the New York University for many years.

SIR JAMES RISDON BENNETT, M.D., LL.D., F. R. S., president for four terms of the Royal College of Physicians, London, died December 15, aged 82 years. He was identified for many years with St. Thomas Hospital, holding the chair of theory and practice, and becoming later honorary physician and governor. He was a representative of his College in the Royal Medical Council and vice-president of the Royal Society. He was chairman of the executive committee of the International Medical Congress.

THE DEVELOPMENT OF THE SECTIONS of the American Medical Association has occupied some of the attention of Dr. Leartus Conner who, at the last meeting of the Association formulated his views as follows: 1. The sections are the Association, and should conduct its affairs. 2. The simplest method of attaining this end is to have each Section appoint an executive committee of three to look after the interests of each individual section, and to unite with a similar committee from the other sections to form a section council. 3. This council should have charge of all affairs of the Association that bear upon the development of the sections. 4. The members of the several section executive committees should be appointed for three years, and be composed of ex-chairmen of the section, the retiring chairman of each year filling the vacant place of the retiring member. The details of the plan can readily be made to fit into the existing state of affairs, when once our first proposition is admitted.

The section in ophthalmology ratified this by electing three members and now the originator of this method is desirous of having every other section do the same at the next meeting. There is no doubt that such a section council could wield a large influence for the bettering of the sections.—*St. Louis Med. and Surg. Journal.*

ALKALIES IN UNIVERSAL PRURITUS.—Lange (*Hospitals-Tidende*, No. 21, 1891) has found that sodium bicarbonate and lithium carbonate, combined with carbolic acid compresses, have a very prompt effect in relieving universal pruritus. He refers to an extreme case in which the condition was improved in a few days, with marked relief in six weeks, and in three months hypnotics were unnecessary.—*British Med. Journal.*

TREATMENT OF CONVULSIONS IN CHILDREN.—T. G. Davis recommends, if the patient is cyanotic, a few whiffs of amyl-nitrite.

A HYPNOTIZER IN JAIL.—A man, calling himself Dr. Vint, has been sentenced to three months at hard labor, in England, for giving exhibitions of alleged hypnotism.

THE
Journal of the American Medical Association
PUBLISHED WEEKLY.

SUBSCRIPTION PRICE, INCLUDING POSTAGE:
PER ANNUM, IN ADVANCE $5.00
SINGLE COPIES . . . . . 10 CENTS.

Subscriptions may begin at any time and be sent to
THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION,
No. 68 WABASH AVE., CHICAGO, ILLINOIS.

All members of the Association should send their Annual Dues to the Treasurer, RICHARD J. DUNGLISON, M.D., Lock Box 1274, Philadelphia, Pa.

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This is obtainable, at any time, by a member of any State or local Medical Society which is entitled to send delegates to the Association. All that is necessary is for the applicant to write to the Treasurer of the Association, Dr. Richard J. Dunglison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own Society, signed by the President and Secretary of said Society, with five dollars for annual dues. Attendance as a delegate at an annual meeting of the Association is not necessary to obtain membership. On receipt of the above amount the weekly JOURNAL of the Association will be forwarded regularly.

SATURDAY, JANUARY 16, 1892.

METHODS OF MEDICAL INSTRUCTION.

This always interesting, always threadbare, but never worn out subject, was a theme of discussion in a recent meeting of the Practitioners' Club of this city. There was a general harmony of views expressed by the speakers, all of whom are active teachers and represented the several medical colleges of Chicago. While, as the honored guest of the occasion, PROFESSOR VAUGHAN, of the medical department of the University of Michigan, presented his views.

PROFESSOR E. L. HOLMES urged the necessity of more and better laboratory instruction, claiming that the laboratory work should be extended, and in conjunction with the clinic, be made the manual training school of the medical student.

PROF. QUINE urged the importance and value of the didactic lecture as an important factor in the teaching of medicine, and deprecated the giving of clinics before large classes. PROF. VAUGHAN said text books could never take the place of the living exponent. That the art of the professor is not only to instruct his class in the fundamental truths of his subject, but to infuse them with a spirit of investigation and to make his pupils feel that they must learn to think and act for themselves. Laboratory work and laboratory teaching is only in its infancy. Much is to be hoped for in this direction. PROF. VAUGHAN paid a generous and glowing tribute to DR. JOHN H. RAUCH, the late secretary of the Illinois State Board of Health, for the great work he had accomplished in elevating the standard of medical education in all the medical colleges.

PROF. CHRISTOPHER spoke of the special value of clinical instruction when given to individuals and small classes.

Others spoke with deprecation of clinics given before large classes.

The entire discussion of the evening was very satisfactory in giving those who were present an opportunity to hear an expression of thought on this subject by prominent and successful educators.

It is quite evident that there is a feeling of unrest and anxiety for better methods of teaching medicine on the part of the most experienced teachers.

A subject not touched upon, for lack of time, was the trend of the period in the affiliation that is taking place between the Medical Colleges and the Universities. In most instances as yet this affiliation is only nominal, but it is the first or initiatory step toward a more practical connection. A University in name is not a University in fact without it has a medical department with its medical teaching faculty. The one is a normal part of the other. When an absolute unification of medical schools in and with the universities does come about, there will follow a strength and power for advancement which does not and cannot otherwise exist. With such a unification of interests there will naturally succeed an endowment of laboratories, professorships, fellowships, and scholarships which will not and can never come under other conditions.

Within the last very few years—we might almost with propriety say, within the last very few months—there has been a rustling and a rattling, as of dry bones, indicative of a change of thought, an evolution of sentiment amounting to a tacit demand, that is a sure premonition of a forward movement all along the line. The several State legislatures are, one after another, with reasonable rapidity, enacting laws having for their purpose an elevation of the standard of educational requirements for the privilege and right to practice medicine. This is not in a broad sense a system of class legislation, for such Acts are for the common conservation of the health and lives of all the people.

A NEW METHOD OF INDUCING LOCAL ANÆSTHESIA.

DR. LEONARD CORNING has described in the *New York Medical Journal*, December 26, 1891, a novel procedure by which he obtains a protracted loss of sensation, without freezing the tissues. He uses a double hypodermic syringe with a single needle. One barrel of this syringe contains a solution of muriate of cocaine, while the other has a pure, non-irritant oil, preferably the oil of theobroma, or "cacao butter," as it is commonly named. The strength of the cocaine solution should be two or three parts of the salt to one hundred parts of water. The oil of theobroma in the larger barrel of the syringe is maintained in a fluid state by occasionally dipping the syringe into water of about 110° F. The cocaine is first thrown into the tissues that are to be made insensitive, then, without removing the needle, the cacao oil is made to follow along the same path. By the next step, which is the original feature of the procedure, cold is applied over the surface, and the oil is precipitated or

solidified, obstructing the capillary circulation, and thus producing a local stasis that "anchors" the cocaine solution. By this method, DR. CORNING has maintained a "limited zone of anæsthesia" for more than an hour, and he sees no reason why he may not double that period of insensitiveness, if desirable. The chilling of the surface, in order to harden the subcutaneous injection of oil, may be effected either by cold water, ice, or by the ether spray; the latter being the preferable way. The spray does not need to be continuous, since an occasional refrigeration is adequate to keep the oil solid, provided that the temperature of the anæsthetized part is kept below 86° to 95° F., which is the melting point of cacao butter. When the local anæsthesia is no longer required, the oil is melted by the heat of the body, and is taken up into the general circulation, when the application of external refrigeration is discontinued; even during the application of cold, there is a gradual melting of the solidified oil, beginning at the periphery. In consequence of this fact the anæsthesia begins to fade away at the periphery. But this subsidence of the anæsthesia may be markedly retarded by simply taking up the "slack of the skin" outside the oil-injected surface. This is done by pinching up a fold of skin and holding it thus doubled by means of small spring clothes-pins or by narrow strips of elastic adhesive plaster. But this step does not imply that a stretching of the skin is essential to the attainment of the most complete results. It is simply a removing of the excessive elasticity of the skin over the injected area. DR. CORNING has hope that the method of protracted localization of remedies may be found useful in a variety of ways beyond that which has first suggested itself, in the employment of cocaine and cacao butter for the induction of a protracted anæsthesia serviceable to the surgeon.

PHYSICIANS AS POLITICIANS.

At a recent gathering of members of the medical profession in this city, a distinguished gentleman arose to direct attention to the fact that in the great Cook County hospital the teaching of students was absolutely prohibited, and at once entered upon a tirade against politicians and their methods, saying he hated them as he did sin and the Evil one.

We could not but think the gentleman was one of a great number who imagine themselves particularly good because they keep aloof from politicians. In this he plays a very unwise part. If he and his kind mingled a little more closely with politicians, and showed the ward statesmen that he was individually interested in the management of city and State affairs, there would be a good deal more respect for each other manifested on all occasions; for the truly good doctor need not think that any more than half of the disrespect there is going, is on his side of the house.

Let the good doctor at the very next municipal election, or a little before the election, gather together at his house a dozen of his personal friends and neighbors, and there and then formulate a ticket of men that he and his friends believe to be good, true and capable of representing what he regards as the best interests of the city and State. This being done, let him and his friends agree to go to the polls, and stay there during all the hours the polls are open, and solicit the vote of every man who comes there to exercise the rights of citizenship. Then let the good doctor go to the convention, if only to see how the meeting is managed. The candidates for office having been selected, the doctor should not cease his labors but should go to the church and prayer meeting, if need be, to meet his friends, and to urge their going to the polls. There is a deal of religious duty in such an effort to secure a righteous government. This being done and well done, the doctor may not, at the very first attempt, see his nominees elected to office, but he will have accomplished a great deal in the way of obtaining the respect of the now hated politicians, and this respect will be reciprocal. Some practical attention in this way to ward statesmanship, will very soon fling wide open the doors of Cook County hospital, the insane asylum and every other public institution which the good doctor wishes to enter with his students.

Not only so, but the good doctor would have a most respectful hearing of and a heeding to his statements, when showing the county authorities whom he helped to nominate and elect to office, where the branch hospital for contagious diseases should be located.

We have not one particle of sympathy for the goody good doctors who inveigh against politicians and their methods, and go up to the temple and there, with solemn and elongated countenances, thank the Lord they are not as other men, not even as the poor politician, who comes in hanging on to a good wife's apron strings.

Every time, the doctors can have their own way in everything that pertains to the conservation of the health of the people, and secondarily of their own public interests.

RIGHT ILIAC DISEASE.

More particularly of late years have diseased conditions in the right iliac region attracted attention, and the terms typhilitis, perityphilitis, and appendicitis, have been much discussed. The surgeons have about decided that appendicitis is the correct term, and that appendicitis is the initial lesion of all so-called inflammatory disorders of the right iliac region, which have any connection with the bowels.

The paper of DR. JOSEPH PRICE, on appendicitis, read before the Philadelphia County Medical Society, Sept. 28, 1891, may be taken as a fair index of the

state of the surgical mind regarding this subject.

Dr. Price says: "The old terms were arrived at by examining old, neglected cases, often post-mortem. Recently but one term—appendicitis—is used before laparotomy, before post-mortem, because those two performances prove that so far as the gravity, intensity, and extent of the disease are concerned, the symptoms are unreliable, inadequate; further abdominal sections and post-mortems have determined what the treatment should be—that is, surgical, under a surgeon from its inception; hence the name indicating and impressing the nature of the disease, and the character of the treatment—that is, appendicitis surgicalis. Idiopathic peritonitis indicates nothing—is an empty term. The terms typhlitis, perityphlitis, paratyphlitis, extra-peritoneal abscess of the right iliac fossa, are useless except to indicate a secondary or late process originating, without exception, in inflammation of the vermiform appendix."

This language is certainly misleading. That the great majority of cases of right iliac disease are of a mild type, and amenable to medical treatment, is well known to the medical man, if not to the laparotomist.

A little later in Dr. Price's paper occurs this statement: "Thirty-five per cent. of all post-mortems show residua of appendicitis; 36 per cent.—over one-third—of 300 autopsies done at random, revealed diseased appendix (Toft). One case of perityphlitis to 100 of appendicitis (McBurney). Assume that one-third or more of all adults have one or more attacks (Keen)." With these statements the physician can agree. But how common laparotomy would become, if all these cases required that operation. As a matter of fact, these figures show very conclusively, not only that appendicitis very rarely requires surgical intervention, but that, in many instances, it must be so mild as not even to be suspected.

The sweeping assertions of the surgeons relative to the necessity for operation in most cases of appendicitis, are no doubt made in good faith, and as the teachings of a rich experience, but these assertions certainly do not harmonize with the daily observations of physicians, and the explanation of these differences of opinion can only be found in the supposition that the great majority of the cases which are brought to the attention of the surgeon, or rather the laparotomist, are cases which do require or have required operation; while the physician is concerned with another type of cases.

The results accomplished by surgery, in cases which would have proved fatal under purely medical management, are exceedingly encouraging; but the indications for surgical interference should be clearly understood by the physician, before he requests the services of the surgeon.

A clinical lecture by Jules Simon,[1] at the Hôpital des Enfants, Paris, sheds much light upon another phase of the question. Prof. Simon's observations have been made mostly upon children, but are applicable to adults, particularly as, in many instances, the trouble in the adult is a heritage from his childhood.

One case which Simon reports indicates very well his general views upon the subject. A little girl, 6 years of age, who had been the subject of an obstinate constipation since her earliest infancy, presented evidences of cæcal obstruction, followed by diarrhœa, and inflammation of the region. She was put upon treatment, and at the end of three weeks was entirely well, not even the least difference in suppleness of the two iliac regions being apparent. The mother was cautioned to look out for relapses, and particularly to watch for signs of constipation, and to prevent it. In spite of his injunctions, the hygienic measures which had been prescribed were disregarded, and a year later, the child was taken with typhlitis, then appendicitis, and finally with perforation, rapidly terminating fatally. Simon believes that in this case, prolonged constipation produced a dilatation of the cæcum, hardened fæces irritated the intestinal walls, the appendicular orifice became dilated, foreign bodies entered the appendix, with resulting ulceration and perforation. Whether this explanation is correct in every detail, may well be questioned. As pointed out last week, a further investigation of the relations of the bacterium coli commune to appendicitis, must be awaited. But this much is certain, obstinate constipation, and some form of right iliac disease, preceded the fatal appendicitis.

In this connection Simon says: "In all the cases that I have investigated, either in private or hospital practice, I have observed the same pathological evolution, and in cases where a special hygiene was observed, and suitable treatment (laxative) instituted, and faithfully carried out, the patients always escaped further accidents." With these statements many medical men will be found to agree.

Simon recognizes three stages of the disorder, preliminary to appendicitis. 1st. Simple constipation; 2nd. Engorgement and thickening of the cæcum; 3rd. Stecoræmia, or constitutional manifestations from the retained fæces.

It is not uncommon to find cases of rather sudden pain in the right iliac region, with more or less tenderness when pressure is made over the appendix. There may also be present a nervous condition simulating shock, a rapid pulse, and some mental anxiety. There may or may not be elevation of temperature. Tenseness of the abdominal muscles with possibly induration of underlying tissues is usually present. In view of the revelations of the post-mortem table these cases ought to be classed as appendicitis. While the history may not always indicate preceding constipation, flushing the bowels will almost always

[1] Le Bulletin Medical, September 9, 1891, p. 849.

bring to light old, hardened masses of fæces. An immediate exciting cause, such as shock, trauma, exposure to cold, indiscretion in eating, may often be found. Often it is a mere coincidence, but in some instances may be the reason for the occurrence of the appendicitis at that time. Appendicitis, however, would not have occurred from the particular exciting cause, if the preceding predisposing conditions had not been present. Now if these cases are appendicitis, then appendicitis is only occasionally a surgical disease, for the vast majority of these cases recover promptly under such widely different lines of medical treatment as laxatives, with poultices locally, or the free use of opium. While favoring the laxative plan of treatment we cannot here discuss the relative merits of it and the opium treatment.

In closing, we wish to repeat, and approve SIMON'S words: "I admit, for my part, all that appendicitis has revealed at autopsies; it is the cause of the adhesions, the abscesses, the escape of foreign bodies into the peritoneum, under the peritoneum, and even into neighboring cavities; but I cannot repeat too often, that in my opinion, appendicitis is a result, and the so-called premonitory period is the cause."

Right iliac disease is very common; it usually yields to medical treatment; its great danger is progressive appendicitis.

TUBERCULOCIDIN. — The first installment of the purified tuberculin, prepared by Klebs, of Zurich, has been received by Dr. Rachel, of New York City. It will be used at once in the treatment of some cases of tuberculosis in a private hospital conducted by Dr. Rachel. This "tuberculocidin" is stated to be an attenuated form of Koch's lymph, and is relatively free from the "reaction fever." The name tuberculocidin was given by Klebs to this preparation of his, to signify that it has the power to destroy the bacillus of tuberculosis to an even greater extent than the tuberculin of Koch, and to have an even wider range of therapeutic activity.

THE *Medical Fortnightly*, of St. Louis, Dr. Bransford Lewis, Editor and Publisher, and *The Doctor's Weekly*, of New York, Dr. Ferd. King, Editor and Publisher, make their *début* with the advent of the new year. The appearance of both publications is highly creditable, but not more so than we should expect, with such well-known and experienced journalists as Drs. Lewis and King as managers.

MEDICAL DEPARTMENT OF THE UNIVERSITY OF MICHIGAN.—The first ward of the new hospital of the medical department of Michigan University, is now completed and will be formally opened by the Governor of the State, Jan. 20th. On this occasion an address, "The Hospital: an element and exponent of Medical Education," will be given by Albert L. Gihon, A.M., M.D., Medical Director, United States Navy. The hospital was designed by Chamberlain and Austin of Boston, and E. W. Arnold of Detroit, and is supplied with modern hospital appliances. The ward just completed contains clinical amphitheatre, consultation rooms, offices and accommodations for eighty patients. It has cost about eighty thousand dollars. The plan provides for three additional wards, the erection of one of which will be begun during the present year.

SOCIETY PROCEEDINGS.

NEW YORK ACADEMY OF MEDICINE.

Section on Orthopædic Surgery.

Stated Meeting Dec. 18, 1891.

SAMUEL KETCH, M.D., CHAIRMAN.

CONGENITAL ABSENCE OF A PORTION OF BOTH LOWER EXTREMITIES.

Dr. John Ridlon presented a boy, ten years old, who had been brought by Dr. Manning to the last meeting of the Hospital Graduates' Club. There was an entire absence of all the parts below the condyles of the fumur, and just posterior to the extremity of each of these stumps, was a fleshy mass, which probably represented the undeveloped digits. The boy could walk quite well on these stumps, and at present was wearing artificial limbs, but as these caused pain, he had presented the boy with the hope that some suggestions might be offered as to the best way of treating the case. It was questionable whether an artificial leg with a joint at the knee could be applied to the limbs of this length, and hence, the question of amputation might properly be considered. Personally, he was in favor of applying artificial legs without any knee joint, directly to the stumps without operative procedures.

Dr. W. R. Townsend thought that the fleshy masses would interfere with the proper application of these artificial limbs, and hence, favored removing them.

Dr. J. E. Kelly thought the fleshy masses were undoubtedly the remains of the undeveloped lower portions of the limb. He thought their position the normal one in utero. He had seen within the last few months a somewhat similar amputation in the upper extremity, with rudimentary digits which were capable of movement.

Dr. Halsted Myers, on examination, found a slightly movable bony mass between the condyles of the left femur, probably a poorly developed patella. He thought the case one of non-development, not amputation.

Dr. Myers presented a case of congenital deformities of the upper and lower extrèmities, and asked the opinion of the Section as to the value of operative procedures for the relief of the constrictions caused by amniotic bands.

Dr. Kelly thought the phalanges of the great toes were perfect in this case, but that the digits had been suppressed, and development had taken place beneath the skin.

The Chairman referred to a child he had seen in which there had evidently been an attempt at amputation in utero. There was a deep constriction just above each ankle, more marked, however, on one side. The mother of this child, quite early in pregnancy, was tripped by a cord which some boys had tied across the street, and it was thought that this maternal impression was responsible for the deformity. The child has been able to walk with the aid of ordinary ankle supports.

Dr. Townsend did not favor operating upon these constrict-

ing bands, for the resulting cicatrix would cause further contraction.

Postponed discussion on Dr. J. E. Kelly's paper on "The Anatomy of the Foot, with Exhibition of a New Club Foot Shoe."

Dr. Royal Whitman said that the author had spoken of removing a wedge-shaped piece from the cuneiform bones, but as these bones were quite small, their dimensions varying from one-half to one inch, it was evident that a cuneiform osteotomy on such bones would be impracticable. The calcaneus could, of course, be treated in this manner by cutting to a considerable depth, but such an operation was totally unnecessary. When one recalls the fact that the astragalus is poised on the os calcis in unstable equilibrium, there seems to be no reason for increasing this instability. Such operations might be allowable if it were true, as had been stated before in the Section, that the radical cure of flat-foot was impossible, and that all that could be hoped for was relief. He had seen more than three hundred cases of flat-foot, and he believed that a radical cure without operation was not only possible, but easy.

Dr. A. B. Judson said that the mechanical toy constructed by Dr. Kelly, admirably illustrates the fact that human locomotion resembles the action of a wheel in motion, in which the legs are the spokes, and the feet are the felloes, as pointed out by Dr. Holmes. That ordinary locomotion is a continual falling, and a continual recovery is seen in the gait of a child learning to walk, and in the titubation of a drunken man whose body inclines in a given direction, and would fall if the legs and feet failed to make a timely movement forward to prevent a fall.

Dr. Judson said that Dr. Kelly's apparatus takes advantage of the weight of the body for the correction of the varus. It is well known that varus, corrected to a certain point, and held there, is further corrected by the weight of the body applied in successive blows, as the child runs about. On the other hand, if the varus is reduced only to a point on the wrong side of the line between deformity and symmetry, each footfall is a blow increasing the varus. Dr. Cook, of Hartford, had shown a varus shoe at Washington last summer, which had attached to the sole, a flat piece of steel extending outward a few inches to enable the weight of the body to act in a favorable manner on the deformity. He had seen a horse treated for some affection which made it desirable to prevent extension of the foot, by the application of a horse shoe having a long posterior prolongation. The veterinary surgeon can attach his apparatus with absolute firmness to the foot, but in our patients, the foot is liable to turn over inside of the shoe. As a rule, the weight of the body can be made more effective by the use of an apparatus having an upright extending up the leg, and a steel foot piece in which the foot is prevented from rolling by a strip of adhesive plaster.

Dr. R. H. Sayre said that this succession of falls during the act of locomotion, was well shown in instantaneous photographs of athletes running. The shoe exhibited by the author was doubtless intended for the treatment of club-foot in the later stages, when it was possible for the foot to be placed flat on the ground in a fairly good position. Before this stage, the shoe could not be easily adapted to the crooked foot. The usefulness of this "snow-shoe" was not so much on account of its shape, as of the fact that there was a long lever on the outer portion of the foot, which prevented the child from standing on this outer portion.

In connection with this shoe, he had intended to exhibit a shoe which one of his patients devised for his own use. His shoe was made with the sole sloping outwards for some distance, thus answering the same purpose as the snow-shoe. This patient had adhesions and contracted tendons following infantile paralysis, so that the weight of the body was unable to do more than prevent an increase of the deformity. The foot was only brought straight by subcutaneous tenotomy and the use of very strong force, applied by means of Bradford's instrument.

The Chairman said that many instances were recorded in which this principle of utilizing the weight of the body had been embodied in various kinds of apparatus. In some cases of equinus, the patients have been allowed to walk without apparatus, with the idea of utilizing this factor.

Dr. Royal Whitman read a paper entitled

A CONSIDERATION OF SOME OF THE AFFECTIONS OF TENDON SHEATHS AND BURSÆ, AND THEIR RELATIONS TO INJURIES AND DISEASES OF THE JOINTS.

He briefly described the structure and anatomical relations of bursæ and tendon sheaths, their diseases, and appropriate treatment, calling attention to the fact that chronic disease of tendon sheaths was usually tuberculous in character, for which early removal was the only remedy.

The relation of the tendon sheaths to the ankle and wrist joints, and their liability to injury in sprains and fractures, explained the symptoms—weakness, local pain, and limitation of normal motion, often persisting after such injury.

The importance of local massage and stimulation in the early stage, in order to prevent the formation of adhesions after secondary inflammation of tendon sheaths, was urged.

In chronic and neglected sprains, a careful examination should be made, and if adhesions or contractions were present, treatment should be directed to a recovery of the normal range of motion. This result might often be accomplished by a forcible over-stretching, under ether, followed by massage and support. By such treatment, patients disabled for many months might be quickly and permanently relieved.

In conclusion, attention was called to the importance of slight injuries in childhood, which might be the starting point of tuberculous disease, the diagnostic value of chronicity, and the necessity of careful observation and early treatment in suspicious cases.

Dr. Judson said that he had seen a tumor of the semimembranous similar to the one shown in the model. The child was about 6 years old, and under a purely expectant treatment, the tumor disappeared in the course of a few months, leaving no deformity or disability.

Dr. Townsend said that he had seen many of the cases referred to by the author, and he had been struck with the many and varied diagnoses which had been made upon them before they came to the dispensary. The diagnosis in the early stages is often difficult, especially when there is only a meagre and often misleading history, such as accompanies most dispensary cases. The importance of differential diagnosis could not be too strongly emphasized, particularly as upon it depended a correct prognosis.

Dr. C. A. Powers said that he inferred from the author's remarks on injuries at the lower end of the radius, that he recommended confining the flexor and extensor tendons of the fingers in the treatment of Colle's fracture. He saw a large number of these cases with functional disability following this method of treatment, and he therefore preferred to use the long anterior splint for the first five or six days, and then to shorten both the anterior and posterior splint to the first row of the carpus, directing the patient to make very active use of the fingers. Four or five days after this, he expected them to be able to shut the fingers well down into the palm.

Dr. Kelly said that in Dublin, the home and birthplace of Colle's fracture, the keel-shaped splint, which avoided injurious pressure on the thenar and hypothenar eminences, was almost universally employed. The mode of development of

the bursæ found on various points exposed to pressure is difficult to understand, unless we remember that the peritoneum, which is the great areolar interspace of the body, has had a similar development from the connective tissue structures.

He was glad that the author agreed with him as to the position of the foot, viz.: slight adduction with the foot at right angles to the leg. This slight adduction produces what he called "artificial talipes varus."

The Chairman said that he inferred from what the author said, that he considered these bursal tumors of tubercular origin. He wished to dissent from this opinion, for many of them were benign, and the result of injury.

Dr. Whitman explained that he had spoken of slow, chronic enlargement of the sheaths of the tendons of the wrist and hand as tubercular. The deep-seated bursæ were favorably situated for tubercular inflammation, and accordingly, when they underwent chronic enlargement, he preferred to treat them radically. He had only incidentally referred to the treatment of Colle's fracture. He did not consider the confinement of the fingers, with vigorous massage and local stimulation, the same as the confinement treatment which had been criticised during the discussion.

Mr. E. E. Hicks exhibited a chair and desk which he had devised, and to which reference was made in the recent discussion on the subject of the relation of faulty attitudes to lateral curvature of the spine.

The desk and seat admit of an independent vertical adjustment, which is manipulated by means of a key. The slope of the desk can also be varied to suit individual requirements. The desks and seats can be folded so as to occupy very little space, thus facilitating cleaning the schoolroom, and allowing room for gymnastics. The seat and desk have a common base of support; a child using the desk, therefore, occupies the seat joined to the desk next behind. This improved desk costs only about fifty cents more than those now found in the market.

Dr. R. H. Sayre thought this desk was a decided improvement on the usual style.

The Chairman thought it might be desirable for a child already suffering from lateral curvature, but he did not believe that faulty attitudes at school were the cause of rotary lateral curvature.

TUBERCULAR DISEASE OF THE VERTEBRÆ IN ITS EARLY STAGES.

Dr. R. H. Sayre presented the second, third, and fourth lumbar vertebræ of a patient, showing a very early stage of tubercular disease. There was a cheesy mass in the third lumbar vertebræ which had not yet broken down and ulcerated through into the cartilage. The points of junction between the second and third and the third and fourth vertebræ were apparently normal. There was an extravasation of blood into the vertebræ. The history of the patient from whom these specimens were taken was quite interesting. A child suffering for some time from chills and high temperature began to have a peculiar posture and mode of locomotion, and to suffer from abdominal pains. This led to a diagnosis of spinal disease, but in a consultation with an orthopedic surgeon this opinion was not confirmed, the latter believing that the child was suffering from malaria. The symptoms not subsiding under the administration of quinine, the child was brought to Dr. L. A. Sayre, who concurred in the diagnosis of the disease of the spine. At this time there was some psoas contraction on the right side, with spinal rigidity and very slight pains. It could hardly be said that there was a kyphosis; the lumbar spine was straight instead of concave. The child was placed in a wire cuirass. About a month later he suddenly developed a temperature of 104°, with vomiting, photophobia, phonophobia, stiffness of the neck, and a rapid pulse. He was then seen by the speaker, who found an abdominal enlargement near the left side of the umbilicus, which could be separated by percussion from the spleen. It was quite freely movable. Small doses of bichloride of mercury were administered, and in a few days the temperature fell to 100°, and remained at this point, and the other meningeal symptoms disappeared. There was no colic, indicating tubercular peritonitis. The child became now even more anæmic than before, and the abdominal swelling increased in size. It seemed hardly possible that the mass could be a psoas abscess, pointing in such an unusual position. After some time the mass became larger and moved toward the posterior surface of the abdomen. In consultation with Dr. W. T. Bull, it was decided to be inadvisable to operate. The child died six days ago, and for a few days before death there was slight jaundice. The post-mortem examination showed that the abdominal tumor was formed by a tubercular mass which united the intestines into one large mass. There were no small miliary tubercles scattered over the peritoneum. One little band pressed upon the gall bladder, and so accounted for the jaundice. The kidneys were firmly bound down with adhesions, and the left one was very large and waxy, and its pelvis was much dilated. There was a large quantity of fluid in both pleural cavities, and cheesy nodules at the apices of the lungs. The heart was enormously thickened. The brain was not examined.

The Chairman thought the symptoms described were more like those of an acute non-tubercular meningitis, as in the initial stage of the tubercular variety a high temperature was unusual, and the pulse was ordinarily slow or intermittent. Then, again, the subsidence of the symptoms was not in accordance with such a diagnosis.

Dr. Kelly called attention to the fact that in the early and late stages of tubercular meningitis the pulse was rapid, while in the intermediate stage it was slow.

Dr. Ridlon said that he inferred from the remark of the Chairman that he shared in the general feeling in the profession that if a child survived, it was proof that the meningitis was not tubercular, and *vice versa*. He desired to dissent from this opinion. Eight or nine years ago he had treated a boy who had suffered from a form of meningitis which several eminent consultants considered to be tubercular; and they had an opportunity of seeing the patient a good many times. The patient was still alive, but he did not believe this proved that the diagnosis was incorrect.

The Chairman said that he had never seen one undoubted case of tubercular meningitis recover, although he believed there were a few such cases on record.

Dr. H. W. Berg was not aware that there was any symptom, either subjective or objective, which would enable one to make a diagnosis between simple and tubercular meningitis. He thought that there was a high temperature at the beginning of a meningitis; it was due to a series of eclamptic seizures which, by paralyzing the heat center of the body, allowed of a sudden rise of temperature.

Dr. Townsend had had an opportunity of seeing a considerable number of cases of tubercular meningitis, almost all of which had been proved by autopsy to be tubercular, and he could not recall any case where there was an extremely high temperature at the beginning.

Dr. R. H. Sayre said that he had looked upon the meningitis as tubercular, because of the very general tubercular infection. The child looked as if it would die within a few days after the onset of these meningeal symptoms, and he was much surprised when the acute symptoms subsided so rapidly. The high temperature might have been due to the abdominal lesions. The extent of the abdominal lesions

was remarkable, as they were younger than the disease in the spine.

DR. T. HALSTED MYERS, Secretary,
24 West 50th Street, New York

American Electro-Therapeutic Association.

First Annual Meeting of the American Electro-therapeutic Association, held in Philadelphia, September 24, 25 and 26, 1891.

(*Continued from page 60.*)

If there are cases where dangerous pressure symptoms are present and other treatments have been tried, then possibly abdominal puncture should be tried, but I think it is a dangerous question to suggest it to the society, particularly when you clothe it with the idea of its being practically without danger.

Dr. Nunn:—I have known of a number of cases of abdominal puncture by Dr. Cutter, and some of these were successful, and they were made very curiously. I do not exaggerate when I say that his needles were bayonettes. He was successful in a large number of cases.

I used puncture a great deal in cases of various kinds, and I have to say that as I bring my mind back to previous to 1876, when I was in Europe and when I was using a needle which was very satisfactory in my hands, I have never had any trouble with it. I first used the ordinary insulated needles such as could be obtained twenty years ago. They were covered with shellac to the point and they required a great deal of pressure to force them through, and caused an inverted cup at point of entrance. To obviate that difficulty I used gold wire, as I could not get iridium. I got a piece of spring wire to make springs of and I coated this with successive layers of collodion and then I got the smallest possible trocar which could be fitted to a canula and I then introduce my trocar and canula and I have a perfect insulation without skin contact. I brought them North and showed them to Mr. Bartlett, and since that I have always used that form. It is very small and you have no skin contact, and you have no recurring sore and can use it anywhere almost. You can regulate the depth of the puncture by the stop on the canula, and if some of the gentlemen here were to try it, I think that they will find it useful in hydrocele and other things.

As to the question of the value of the pole as applied percutaneously: It is a question of a good deal of polar effect, and that must not be lost sight of. When you speak of a particular electrode we do not say where we put them, and I believe before a great many years have passed we will classify our tumors. I do not think that they are always electro-negative or electro-positive. Again, wherever we want specified polar effects we should of necessity place the indifferent pole at the farthest possible point from it. I don't think where you have the two poles within two inches of each other you get the same effect as is obtained when you have them six feet apart. For instance, you have the electrode in the vagina and the other on the abdomen. I don't think you have the same effect as you would have if the other pole was on the foot; you may, but I don't think so.

It is another fact well understood in mechanics that what you lose in velocity you gain in power, and vice versa. I believe that this holds true in the effects of electricity. I believe that you can gain with small currents applied for a long time the same chemical effect as with strong currents a short time. I believe that a certain current will deposit so much silver in a certain time, and I therefore believe that the same chemical effect is produced by small currents a long time as by strong currents a short time. I am not prepared to assert that this is a fact, but I think so. There are a thousand things which come in here, those supersensuous forces which we don't understand, and when the doctor spoke of Dr. Hutchinson's method he touched upon the very soul of psychology.

The remarks of the gentleman from Buffalo, recall to my mind a case which brings up the late Dr. Freeland of Brooklyn, and here again the selection of cases comes in which depends upon a discriminating diagnosis. The physician is born and not made; he must enter into the feelings of the patient, and the time was when the physician had intuition instead of measurement—the thermometer and other instruments which should be used only by mechanics. As I started to say this brings up to my mind a patient who had a fibroid, and was under my care. It was probably as large as a man's head. The patient was suffering a great deal of pain, had considerable fever and was wasting away. Her husband had been, like many other people, dabbling in electricity and he wanted me to puncture. I refused to touch the tumor. I took charge of the case and relieved the patient a great deal, but her husband was in a hurry and he was getting tired and wanted the thing done quickly. He heard of Dr. Freeland, and determined to take her to Brooklyn. I knew that the doctor was puncturing and I told the husband that if he took her there he did so upon his own responsibility. In spite of my advice, however, he took her to Dr. Freeland, who operated on her by puncture and she died in a week.

Dr. Robinson:—I desire to say something in regard to puncturing. I am not a gynecologist and I see few gynecological patients. I am, however, a specialist in electricity. What leads me to make these remarks is one or two ideas brought out in this paper: One is that we can reach these cases without puncture. Where we do not hope to accomplish very much, but where pain is an urgent symptom, it is important to relieve it. I will quote a case I had, and the case was diagnosed as one of fibroid by other physicians, and a surgeon wanted to operate, but the patient was not willing. I am not a surgeon and I do not puncture, as the statistics of puncturing have not been very encouraging. In this case the fibroid was not very large and there was not very much hæmorrhage. The chief symptom was that of excessive pain, and something had to be done. I neither punctured, nor did I use intra-uterine treatment, but I used two large spongio-piline electrodes, saturated with a solution of soda bicarbonate, and put one on each side and passed just as much galvanism through as I could, and that was my limit; and by thoroughly wetting, and I used just as hot water as the patient could stand, I got the abdomen thoroughly soaked and used 200 milliampères. I did this without involving any of the membranes, and I gave her twelve treatments—one every other day. Those severe pains went away and after using twelve treatments running over two weeks, the pains were so much better that she did not mind them; the hæmorrhage had stopped. In that case I took no account whatever as to whether the positive or the negative pole was used; that was not my object—my object was to get the electricity in in order to get the results, and the result was, we got rid of the pain, and I did not have the danger of puncturing or the danger of intra-uterine treatment. Another idea: we do not know how electricity acts, whether it is chemical action or whether it is an indirect action. For a better name I have designated it as a vital action or a stimulation of the nervous force, and of the process of absorption and nutrition. How it is done we do not yet know, and what we call chemical action and electrical action does not cover the ground. There is something beyond that which we have not been able to divine. I hold that the electricity does it, and if I can get it in I do not care, and I think that the percutaneous method is the best.

Dr. Blackwood:—One or two points strike me as important in the paper of Dr. Massey. One is of applying the electricity as near the point where we want it to do the work as is possible. Of course it is easier for those with little experience to see per vaginum than it is to puncture, but I believe that the puncture is far better. As to the fear of bad results afterward from the mere wound in the abdominal walls, it has been shown by the surgeons and laparotomists that where the opening of the abdomen is made aseptically it is not as dangerous as formerly thought. And I believe Dr. Massey is correct in advising puncture as much as possible.

My friend from Savannah spoke of the advisability of of having the electrodes as far removed from each other as possible when we desire to obtain polar effects. I did think some time ago that the poles were used too near each other, and as an experiment I have used the indifferent electrode as far from the uterus as possible; but it was not that I expected to get a more decided polar effect in doing that, but to get away as far as possible from influencing the abdominal sympathetic. I have seen some disastrous effects in using galvanism in fibroids, which I consider were due to the close proximity of the solar plexus. But in the simple experiment which I have performed, for instance, by using a piece of meat one inch thick you get the poles very close together, and yet you get absolute polar effect; so that as to polar effects I do not think it makes any difference how close they are together. Another point is, I have never been able to satisfy myself that very mild currents of from five to ten milliampères will produce the same effect, no matter how long continued as a decided current. There is a great deal in jugulating a thing. Many things have been played with; as, for instance, the use of antipyrene in five grain doses, when twenty or thirty grains would settle it at once. I have used electricity in delicate ladies, very mild currents and prolonged administration, and repeated more frequently than I would powerful currents; but I do think that there is a tendency to try too small doses. It is not only the administration of it, but the mode of its administration, and we have been losing sight of the quantity of electricity. I think it is valuable, and, so far as I am concerned, always want to know just how much electricity I get into the patient.

Dr. Massey: I feel complimented at the discussion which has followed the reading of my paper. We cannot come to any conclusion at this time in regard to the subject; we can only suggest and add to each other's personal acquaintance with it.

It has been said by some that this method by puncture is dangerous, and that possibly in sending it out to the electro-therapeutic users throughout the world greater caution should have been urged, for we all know that the method of Apostoli has been sadly abused by many. One of the dangers, of course, and one which has not been very much mentioned, is that of including the intestines in the puncture through the abdomen. By inadvertence, puncturing the convolutions of the intestines which have become adherent to the tumor and got between the abdominal wall and the latter, will sometimes occur. I had some fears on that subject, and a few days ago, when I was in Washington, I had a conversation with Dr. Emmett upon it. He spoke of a case—that of an ovarian tumor—which upon his opening the abdomen was unexpectedly found to be overlaid by intestines to such an extent that the operation was abandoned. There was no resonance there, and there were no gases. That would have been one of the dangerous cases. There is also danger of sphacelation of the tumor, due to the eschar. So far as I have seen, in the cases which I have had, none of these complications have arisen.

The possibility of this method seems to me illimitable. May not some of the troubles of the persons who have used abdominal puncture been due to the fact that both poles were used with a current of necrotic power? This, of course, in addition to the possibility of sepsis. I see no reason, if it is used carefully and the point of the needle made aseptic, why negative puncture may not be carried out without a chance of sphacelation, as it is well known that the alkaline products which collect at this pole are easily absorbed, thus presenting an ideal method of immediate reduction in addition to the galvanic effects proper.

(To be continued.)

MISCELLANY.

THE CHARACTERS OF THE PRESENT PANDEMIC OF INFLUENZA.—According to observations made at recent meetings of the Berlin Medical Society, it would seem that the epidemic of influenza began there during the first week of November, the earliest cases admitted into hospital having come under treatment on November 7th. Ruhemann stated that the most noticeable difference between this and the other recent epidemics has been the large number of women and children, and the small number of outdoor workers attacked. Guttmann mentioned an instance in which the admission of a single patient from influenza was shortly followed by the occurrence of 13 fresh cases. Fränkel, who took notes of 138 cases, found that only 9 (6.5 per cent.) had suffered from the disease before. The chief complications have been pneumonia and heart failure. The effect on the death-rate in Berlin has not been so marked as during the last epidemic, but it has been considerable (27 per mille as compared with an average of 18). In other parts of Germany the effect has been more marked; thus official statistics show that the death-rate has been doubled, or nearly double, in several towns. It rose, for instance, to 44 in Posen (average 21), to 45.6 in Frankfort-on-Oder (average 23.2), in Bremen to 34.3 (average 17.1), and in Rostock to 33.5 (average 15.6).—*Brit. Med. Jour.*

OFFICIAL LIST OF CHANGES in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from January 2, 1892, to January 9, 1892.

First Lieut. James D. Glennan, Asst. Surgeon U. S. A., is granted leave of absence for one month, on surgeon's certificate of disability, with permission to go beyond the limits of the Department.

Capt. Samuel A. Robinson, Asst. Surgeon U. S. A., granted leave of absence for twenty days, to take effect on or about January 2, 1892.

Major Alfred A. Woodhull, Surgeon U. S. A., having returned to the United States, is relieved from further duty and station at Ft. Sherman, Idaho, and assigned to temporary duty in New York City.

Major Julius H. Patzki, Surgeon, and Capt. Henry G. Burton, Asst. Surgeon, having been found incapacitated for active service by army retiring board, will proceed to their homes, and on arrival there, report by letter to the Adjutant General of the Army.

Major James F. Kimball, Surgeon U. S. A., is granted leave of absence for six months, with permission to go beyond the sea, to take effect on or about January 27, 1892.

Capt. Jefferson R. Kean, Asst. Surgeon U. S. A., leave of absence on surgeon's certificate of disability is extended three months, on account of sickness.

Official List of Changes in the Medical Corps of the U. S. Navy, for the Week Ending January 9, 1892.

Asst. Surgeon M. R. Pigott, from hospital, Marc Island, Cal., and to U. S. S. "Baltimore."

Asst. Surgeon E. R. Stitt, from U. S. S. "Baltimore," ordered home, and two months' leave of absence granted.

Asst. Surgeon M. S. Guest, to the Navy Yard, Norfolk, Va.

Medical Inspector C. H. White, from the U. S. S. "Charleston," proceed home, and granted two months' leave.

Surgeon J. B. Parker, ordered to the U. S. S. "Charleston."